MAY-JUNE, 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

The Alcoholic Marriage

Unmet Needs—The Soil Of Addiction

Alcoholism-Guidelines For The Family

Guest Editorial—The Common Ground

How Alcohol Affects The Body

Letters To The Program

What's Brewin'?

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME X NUMBER 1

MAY-JUNE, 1960

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

BUTNER, N. C.: Dr. Roy Berry, formerly on the staff of McCain Sanitorium, has recently joined the staff at the ARP Treatment Center in Butner as the Center physician. We welcome Dr. Berry to our "family", and hope that his stay with us will be long and enjoyable.

NEW HAVEN: Yale University's eighteenth Summer School of Alcohol Studies will be held at New Haven from June 26-July 21, 1960. Lectures, seminars, and workshops on alcoholism will draw persons in many fields of work to the New Haven campus. Outstanding leaders in the field of alcoholism will be on hand to bring to those persons attending the course a better understanding of this illness.

OSLO, NORWAY: According to the Norwegian Statistical Bureau, Norwegians are consuming more alcohol every year. Money spent last year for liquor, beer and wine was up 6.5 per cent over the previous year.

BOSTON, MASS.: The Boston Committee on Alcoholism, Inc. recently held a public education session oriented to early intervention and prevention of alcoholism. The series consisted of concentrated informational sessions in which recognized authorities on alcoholism utilized training techniques developed in business and industrial training programs.

DURHAM: Philip M. Bolich was recently elected chairman of the Durham Council on Alcoholism, Inc. Mr. Bolich succeeds Dr. Thomas T. Jones, who resigned from the post after many years of service. Dr. Jones was named chairman of the rehabilitation committee. Wesley Aitken was elected vice-chairman, and Mrs. Olga Davis was named for another term as secretary-treasurer.

RALEIGH: The annual State convention of Alcoholics Anonymous was held in Raleigh May 20-22. Approximately 700 AA's from all over the state attended.

LAKE JUNALUSKA, N. C.: The 10th annual Institute on Problems in Tuberculosis Control will be held on the Methodist Assembly grounds at Lake Junaluska June 26-29. The theme this year will be Alcoholism and the Tuberculous Patient. Dr. Norbert L. Kelly, Associate Director of the NCARP, will be one of the program speakers.

PARIS, FRANCE: The International Commission on Alcoholism in Industry will hold its first session June 8-10, 1960 in Paris, in association with the Conference of French Industrial Enterprises on Safety at Work and Alcoholism.

BOSTON, MASS.: PERCEPTION, the Boston Committee on Alcoholism's newsletter, reports that Philip M. Morgan, president of Morgan Construction Company in Worcester, Massachusetts, was elected chairman of the board of the National Council on Alcoholism at the annual meeting in New York on March 25. Mr. Morgan was the first president of the Worcester Committee on Alcoholism.

LONG BEACH, CALIFORNIA: July 1, 2 and 3, 1960 are the dates for the Alcoholics Anonymous twenty-fifth anniversary convention. Thousands of members of AA from all over the world are expected to attend. Some of the program speakers include Dr. D'Alonzo of DuPont, author of a recent book on Alcoholism in Industry; and Dr. John Norris, Medical Director at Eastman Kodak Company, among others.

ATLANTA, GA.: Effective July 1, 1960, the responsibilities and functions of the Georgia Commission on Alcoholism will be transferred to the Georgia Department of Public Health. The present Commission will be an Advisory Committee to the State Board of Health.

MONTGOMERY, ALA.: The Alabama CHALLENGE reports that Dr. Sidney Tarwater, Superintendent of Alabama State Hospitals and Chairman of the seven member board announced that the Commission has granted $3,500 of a needed $60,000 to finance a research project on the study of the effects of alcohol on the stomach and liver. The study is currently being conducted by Dr. Basil I. Hirschowitz, Associate Professor at the Medical School of the University of Alabama and Director of the Division of Gastroenterology.

Interesting Journal

I have been acquainted with your journal for the past six years. I find it very interesting and helpful in understanding persons with drinking problems with whom I come into contact in my work.

Mrs. Frances Butler
Roanoke Rapids, North Carolina

AA Sponsor Writes

I have read with interest some of the past issues of your magazine and would like to receive it regularly. As assistant sponsor of the AA program at the Colorado State Prison, I have an active interest in the problems of alcoholic inmates and parolees. The articles and viewpoints expressed in INVENTORY help me better understand the problems of these men and those who make every effort to help them.

Roy B. Rall
Canon City, Colorado

Valuable Information

As I am a registered nurse in one of our big City Hospitals, I came in contact with your magazine INVENTORY the other day being read by one of the alcoholic patients who comes constantly to our Emergency Ward. I also have a brother who is a Social Worker for the City of Medford and comes in contact with problems of alcoholism daily. We both received some valuable information in this magazine and would like it sent to our home if possible.

Mary Healey, R.N.
West Medford, Mass.

Worthwhile Publication

Through our County Health Officer, who is a member of our church, I have come across a copy of INVENTORY, and find it an extremely interesting and worthwhile publication. I would appreciate very much being placed on your mailing list in order that I may join with the many others who are using your magazine as a helpful resource in working with persons who are confronted with alcoholism.

Reverend W. David Woodruff
Asheboro, North Carolina

Thanks Expressed

I should like to take this opportunity to express my appreciation for INVENTORY. The most recent issue carries some outstanding articles—better than the usual run of good material. We find this material very helpful, and are pleased indeed that you continue to make it available to us.

Roy S. Barber,
Lt. Colonel, Salvation Army
Social Welfare Secretary
New York, N. Y.

Fine Magazine

While working at the Nebraska State Penitentiary in the area of rehabilitation, I noticed your fine magazine being used by members of Alcoholics Anonymous. This area has always been of real interest to me, and I would appreciate very much being placed on your mailing list.

Robert Vogt,
Lincoln, Nebraska

For Distribution

I am a graduate professional nurse and am planning to give a class on the values and uses of periodic reference material to a group of nursing students. Would you please send me eight copies of your latest issue of INVENTORY that I might distribute them among the class members?

Miss Patricia Howard
Syracuse, N. Y.

AA in Bombay

There are about 80 members of the Alcoholics Anonymous here in this city of Bombay and the group is just two years old. A.A. came to India through a Canadian A.A. who was posted on an assignment to Delhi in 1957. We now have A.A. groups in many cities and towns of India: Delhi, Bombay, Mangalore, Bangalore and Calcutta. Bombay, however, has the biggest group, though Bombay is a "dry" state. We don't have much literature on alcoholism. Our country right now is passing through a period of Foreign Exchange difficulties. This has led to drastic restrictions on foreign imports. We are eager to read and learn more about alcoholism. The literature would be of great help to some of our members who are engaged in educational work to enlighten the public on alcoholism.

A.A. Secretary
Bombay, India

Splendid Publication

Thank you for putting me on the mailing list for INVENTORY. This is a splendid publication, and I will look forward to having it from month to month. Best wishes in your good work.

Rev. David Q. Byrd
Jackson, Tennessee

Doctor Writes

I am starting my 11th year working with alcoholics, and INVENTORY is helpful to me in a good many ways. Thank you again for sending it to me.

Harold C. Bonner, M.D. C.M.
Rochester, N. Y.

Real Help

Your bi-monthly publication, INVENTORY, concerned with the rehabilitation of alcoholics, has come to my attention through working with some civilian clergymen in Fayetteville, N. C. I believe that it would be of real help to me in my work at this large Army Post of Fort Bragg. I shall appreciate receiving INVENTORY and shall make it available to other Chaplains at the Post.

Chaplain Gerald J. Gefell
Fort Bragg, N. C.

Nurse Writes

As an instructor of Nursing Fundamentals and of Maternal and Child Health at the New York State University, Upstate Medical Center, School of Nursing, a newly developed two-year program, I am interested in your monthly publication. "Inventory," for use in my courses.

Mrs. Eleanor C. Nolan, R.N.
Syracuse, N. Y.

Constant Use

Once again let me extend to you sincerest appreciation for your continuing to send me INVENTORY bimonthly. I find constant use for the publication, as in many ways I come in touch with persons who are ill with alcoholism, and I am able to share with them some of the material contained in this journal. No other publication is of equal value.

Reverend Samuel M. Houck
Jacksonville, Florida

GUEST EDITORIAL

Inventory

ALCOHOLISM... THE COMMON GROUND

By WILLIAM J. McCORD

EDUCATIONAL DIRECTOR
S. C. ALCOHOLIC REHABILITATION PROGRAM

BAPTIST, Episcopalian, Methodist or Presbyterian—Protestant or Catholic—whether the doctrine of your church calls for total abstinence or moderation, there is still one striking similarity in your congregations and that is the tremendous problem of alcoholism. I dare say that there is not a single church in South Carolina that does not have at least one alcoholic on its rolls, and in many cases they are numerous. Whether we like it or not, approximately seventy per cent of all American adults do use beverage alcohol to some degree, and of this group 1 in 15 are alcoholics. This ratio is steadily on the increase.

Today more than ever before members of all faiths are attempting to cope with this situation realistically. The trend is definitely away from the moralistic and legalistic approach toward the alcoholic. Historically, the minister has been the last person that the alcoholic wanted to see about his problem. The intense guilt feelings which are a part of the alcoholic's illness certainly do not need to be strengthened by a condemning and unsympathetic preacher. This attitude is all that is needed to keep the alcoholic forever away from the church and the minister where real help can and should be offered. It has been said, and truthfully so, that the best treatment for alcoholics is understanding, unsolicited love, acceptance. This is an excellent therapy for most of man's ills today, but especially for alcoholism. Without exception, there is no other person in society today who feels more misunderstood, unloved and unaccepted. Do you and your congregation fulfill these needs of the alcoholic in your community? And while speaking of needs, let's not forget the family of the alcoholic. Here again the minister can be of real help.

Recently I attended a seminar on "The Theology of Alcohol" sponsored by the Methodist Church in the Greenville district. Much of their program was devoted to alcoholism, and I was immensely pleased at the refreshing and realistic approach that this group has taken. The negative approach has been replaced with a positive one, therefore offering a program for constructive

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VOL. X, NO. 1 INVENTORY MAY-JUNE, 1960

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

GUIDELINES FOR THE FAMILY

● *Guidance outside the family circle is often needed to help the alcoholic.*

ALCOHOLISM is a condition that is characterized by uncontrollable or compulsive drinking. Its victims are known as alcoholics. Until very recently it was common to think of alcoholics as people to be shunned, reproached, or ridiculed. They were considered by many to be immoral, weak-willed, or obstinate. But nowadays physicians and others who have made a study of alcoholism approach the problem differently. They realize that there is no point in scolding, shaming, or urging the use of will power alone because they know that once an alcoholic has taken a drink, he is literally unable to control his drinking. He drinks because he feels compelled to, and keeps on drinking even though he may realize that he is harming his health, endangering his job, and hurting the people closest to him, his family and friends.

The National Council on Alcoholism estimates that there are about

Courtesy of the Metropolitan Life Insurance Company

70,000,000 people in the United States who drink alcoholic beverages at least occasionally. Most drink socially with no grave ill effects. But, for about 5,000,000 of these people, the use of alcohol has created very serious problems. Alcoholics do not represent any single group in our population; the majority are definitely not "skid-row" types. Alcoholism afflicts both men and women of all ages and from all walks of life.

Medical science is not yet able to say precisely why some people develop alcoholism while others, who may perhaps be heavier drinkers, do not. A great deal of study and research still needs to be done—and is being done—on the causes of alcoholism. Obviously, no one can become an alcoholic without the use of alcohol, but other factors are also involved. There may be something in the alcoholic's physicial make-up or body chemistry which produces an unusual reaction to alcohol, although such differences have not yet been conclusively determined. Emotional difficulties are certainly connected with alcoholism, and it may well stem from a combination of physical and emotional factors.

Escape Mechanism

Many alcoholics feel unwanted, unloved, frustrated, unsuccessful, angry and fearful, and they attempt to escape from these feelings by excessive drinking. But alcohol magnifies and intensifies the problem. Finally, the causes and effects of chronic alcoholism become so enmeshed that a vicious cycle is set in motion: the alcoholic drinks to live and lives to drink.

Thousands of alcoholics can and do recover, but rarely, if ever, without some some sort of help. The biggest hurdle is for the individual to recognize that the problem exists and that help is needed. Once he is convinced of this, he can be helped, if he wants to be. Usually, of course, family or friends are the first ones to be aware of the problem. It is within the closeness of the family that alcoholism creates the greatest difficulties and the most intense turmoil for everyone concerned.

Outside Help Needed

Husbands and wives of alcoholics are often at a loss to understand what alcoholism really is. Feeling certain that drinking is either deliberate or controllable, they may become ashamed, confused, angry, and frequently helpless. But alcoholism cannot generally be successfully handled by family members alone without guidance from outside. While it is natural for a worried family to try to reason, coax, and even threaten, this so-called home treatment alone cannot be effective. Drinking alone and in secret, drinking in the morning, loss of memory after drinking are some of the serious warning signals that indicate that help should be sought. Fortunately, there are places to turn for help—and taking this first constructive step is the most important thing a person can do to help not only the alcoholic but the whole family as well.

Alcoholics Anonymous is an informal fellowship of men and women who have "learned the hard way" by personal experience with alcoholism. Their purpose is to get sober and, through a program of mutual aid, to stay sober and to help other alcoholics stop drinking and lead normal, useful lives. The only requirement for joining is a serious desire to stop drinking. Their program for recovery is based on 12 steps, the first of which is the admission that they are powerless over alcohol and that their lives have become unmanageable. Whether or not the alcoholic member of the family belongs to AA,

his relatives and friends are welcome to attend open meetings where they can get useful information and helpful suggestions. Since its formation in 1935, AA has had remarkable success with thousands of alcoholics. They claim that about 75 percent of those who have cooperated have recovered. While there is no formal tie-up between AA and physicians and treatment centers, they frequently all work together, accomplishing more this way than if they worked separately. However, physicians and AA members generally agree that most alcoholics must first have the kind of medical care that only physicians can provide. Certainly every alcoholic should be carefully evaluated medically to determine if there is some underlying disease that needs attention.

Moderate Drinking Impossible

There is no specific remedy which makes it possible for an alcoholic to become a moderate, controlled drinker. No alcoholic can safely drink alcohol in any form. Various kinds of treatment exist, but not every alcoholic will respond favorably to the same treatment. After making a thorough and complete evaluation, the physician will determine the method or combination of methods best suited to the patient, depending in part on the individual's personality and on his physical and mental condition.

Psychiatric appraisal can help to determine what is the best approach in a particular case. The treatment of the acute phase of alcoholism is primarily medical, while the treatment of the chronic condition is largely psychological or educational, since the alcoholic must learn to live without alcohol.

Medical treatment is becoming more and more important in furthering recovery. New drugs, available only on prescription, not only help to ease the alcoholic's discomfort but make it possible for him to be receptive to additional treatment.

Psychotherapy is being increasingly used as part of the treatment of alcoholism in many of the alcoholic clinics throughout the country. Its purpose is to help the alcoholic recognize what his problems are and enable him to deal with them without the use of alcohol. Treatment is usually given by a team of specialists which often includes an internist, a psychiatrist, a psychologist, and a social worker. Both individual counseling and group therapy are now being used. The combination of psychotherapy and Alcoholics Anonymous has proved highly effective in many causes.

Family Understanding

In order to help the alcoholic under treatment along the road to recovery, it is important for the family to understand something of his problem. Those close to him will want to talk with the person in charge of the treatment and be guided by his advice. Problems for the family—or for the alcoholic—do not miraculously disappear once the alcoholic has begun treatment. Sometimes even under treatment there may be relapses. These are understandably upsetting. There may be quite a few "slips" or just one, or none. But if they do occur, it does not mean that the situation is hopeless.

Alcoholism takes time to develop, and recovery from it takes time, too. But by understanding that the alcoholic is suffering from a very real problem, members of the family can help both themselves and him to see it through.

The family—especially those members closest to the alcoholic—need to talk to someone about the situation

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UNMET NEEDS:
The Soil of Addiction

By JUNIUS S.

Rejection of the child's normal human needs for love, security and recognition may produce an adult incapable of facing life without alcohol.

WHEN talk turns to alcoholism, invaribly someone in the crowd will top the subject with, "Ah, drunks are a mess." The guy's right, they are. What makes a drunk tick? How did he get that way?

The average alcoholic is a man who, during the years from three to eleven, found himself in a home environment where for some reason he felt "affectionally" rejected—not wholly loved, protected, and wanted. This feeling of being an outsider as it were in one's family, can be caused by many situations within the home—divorced parents, estranged parents, battling parents, drunken parents, a sordid and humiliating poverty of such depth that a child never knows upon leaving for school in the morning whether there will be a roof over his head when he returns at night; the desolate sense of exclusion which follows the showing of marked favoritism for a brother or sister; the discovery of a parent in a scandalous or criminal episode which is much more common than we care to admit; tavern-hopping parents who, when compelled to stay at home for one evening by a childish illness, show only too plainly they consider him a nuisance.

But of all these put together, none equals the sinister potency in creating future alcoholics more than a disciplinarian type of father coupled with an over-soft, over-affectionate, over-possessive mother. The more impossible rules the father lays down for the child to follow, the more failures accumulate, the more bitter the father's persecution, the more maudlin and sentimental the mother's attempts to protect and compensate. Between them they do a job.

Whatever the cause of this sense of rejection, it has a dire effect upon the child. It apparently serves to fix, arrest and freeze his emotional growth in certain parts of his personality at the age level during which experience occurs. This simply means that when the future alcoholic matures later intellectually and

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physicially, he still remains a child of four or seven or none in certain parts of his personality.

Here are a few examples of childish traits which seem to be found in practically all alcoholics. A tantrum type of temper which is natural and usual in a child of four to seven leads to tragic consequences in a man of forty. Let me illustrate here just for a moment.

Five years ago when my youngest daughter was seven she came to me one afternoon at 5:30 and said, "Daddy, I want an ice-cream cone." "No, darling," I replied, "It's just half an hour before dinner and it might spoil your appetite." Whereupon she made a very typical seven-year-old remark, "I don't think you love me anymore; I guess I'll run away." This was kid stuff, of course, but let's look at that remark through cold adult eyes, and note the shocking disproportion between the provocation, and the penalty the child invokes. As for provocation, she has been told very kindly that she can't have a five-cent ice cream cone at a totally unreasonable hour. But the penalty she invokes is to threaten to terminate housing, warmth, clothing, food, care and love. In other words, in childish language she is threatening to destroy herself.

Now let's move up to an alcoholic of forty. He has a job, also a wife and three children. In addition to this, it is Monday morning and he has a hangover. He is still young enough to snap out of it to a certain extent, so he manages to get down to the job. He puts on his mechanic's apron, and starts up his machine. A few moments later the foreman comes along, reaches over and picks up a chart. "Look here, Joe, I've told you many times this thread should go 3/8 of an inch further around the shank." The alky, black with fury, snatches off his apron and throws it in the foreman's face and snarls, "Nuts to you, I quit." Again, notice the terrible discrepancy between the provocation and the penalty. The provocation is that he has had a mistake of his own doing called to his attention, and not too unkindly. The penalty he invokes is to cut off the means to provide housing, food, warmth and clothing for his children, and himself. This is not the righteous indignation of an adult. It is a child of seven destroying himself because he can't have an ice cream cone.

Characteristics of Alcoholics

Unreasonable jealously is very common to the alcoholic. All the welfare workers in the world explaining the falseness of his bitter accusations will do no good, for this thing is not rooted in reason. It is a deep inner disturbance unconsciously created by a mother or a father who, in making a child feel rejected, has set up such a sense of personal unworthiness within him that deep down inside he doubts his ability of holding the affection of anyone. When he drinks, he imagines that the last barrier of adult rejection has been passed.

A selfishness which completely excludes consideration of anyone else is present in almost all alcoholics. It is so complete that it mystifies most of those who know him. He has been condemned to live out his years at a six year old emotional age level, a time in a kid's life when it is normal, natural, and a part of development to be totally preoccupied with self. But there is no evil, no malice in an alcoholic's selfishness. It is unfortunate that he should have to confront adult relationships without the ability to see beyond himself.

At the "social" age, a future alcoholic begins to go to parties, dances, meetings at the church hall, the

lodge hall, and the union hall. He's easy to recognize. He's the guy you see sitting in the corner perspiring in a frenzy of uneasiness. His whole state of mind could be summed up in seven words: "Nobody cares whether I'm here or not." He doesn't feel wanted. He feels that he's not one of the gang. He's afraid to ask that pretty girl across the room to dance. Nobody likes him, and so on. He has transferred his sense of rejection by his family as a child to a rejection now by the whole human race. He is desolate.

Sooner or later some kind-hearted fellow seeing that he is not having a good time walks over to him, hands him a glass, and says, "look Joe, you're not enjoying yourself. What you need is a drink." Joe drinks it, and a few minutes later, he finds that he was mistaken about feeling unwelcome. He is convinced that everybody loves him. He hops up and walks over to the same pretty girl he had noticed before. "Come on, Susie," he says, "let's dance." He has a wonderful evening and his reaction is, "Gosh, where have they been keeping this stuff?"

Alcohol—An Anesthetic

Why did alcohol do this to him? Alcohol is not a stimulant as is commonly believed, but it is an anesthetic. It progressively puts to sleep the various layers of consciousness, and one of the first layers to feel the effects of alcohol is the one which controls the desperate sense of uneasiness which all alcoholics suffer in the presence of mixed company.

The greatest reality of life does not consist of a variety of physical objects. The greatest reality in life is people. Here is a young man who has made his adjustment to people through alcohol. There are two things wrong with this: first, the size of the dose has to be increased constantly as the fellow develops tolerance for alcohol; secondly, having solved his greatest problem, people, he now uses the same adjustment to the other realities of life, namely, responsibilities. Having reached early manhood, he now has a man's duties to perform. He has to buy a car, rent a house, buy a refrigerator, ask a girl to marry him, have a baby in the family, and all sorts of things. As these things present themselves, his instantaneous response is: "Just give me a drink or two and I'll be all right." And he is. He has taken the edge off his unremitting doubt as to his adaquacy in an adult's role. He is not drunk; he has just anesthetized his uneasiness. He goes through with what he has to do.

We now have a picture of a young man who is using alcohol as a cushion between him and the rough give and take of life. He has found the adjustment to his problems. He probably will go along eight or ten years using this crutch to hold himself up. His drinking has not as yet increased immoderately. He's usually on the job in the morning. He hasn't gotten into any serious trouble—perhaps a squabble with his wife, a little slowness paying his bills, perhaps a scratched fender while driving, but nothing serious.

Up until this time, each high, wide and fancy evening has been an episode. But now all this has changed. It is impossible for him to stop drinking. He takes his first "Morning-after" drink to be followed by another gargantuan shot a half hour later. By 9:00 a.m. he is drunk again. This becomes a continuous performance. Thus, what had formerly been just an occasional wild night now becomes a two, three, or four day episode. The rather casual little difficulties which he has experienced in

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DRINKS which contain some alcohol are used by a great many people. Most people drink only small amounts at a time. A jigger of whiskey (1 ounce), or a glass of wine (2 to 4 ounces), or a bottle of beer (12 ounces), contains about an ounce of alcohol. Some people drink somewhat larger amounts, and others drink a great deal at a time. Alcoholic beverages sometimes cause people to behave in strange ways. This is commonly seen. Less easily seen is the fact that some drinkers—those who often drink very large amounts, particularly—come to serious bodily harm.

hol on the body. This means what happens in the body fairly soon after drinking moderate amounts of alcohol, or even large amounts if drunk on rare occasions.

The human body is made up of millions of tiny cells of different types. Each cell is alive and has a job to do, in combination with other cells. Living cells use nutrients—food—from which energy or work is gained. A group of cells of one type is called a tissue. A group of tissues may be combined in certain ways to make up an organ, as the heart or liver. The human body is very efficient because its different tissues

HOW ALCOHOL AFFECTS THE HUMAN BODY

Reprinted by permission of the publishers. Popular Pamplet #3 by Mark Keller. Copyrighted by the Journal of Studies on Alcohol, Inc., New Haven, Conn.

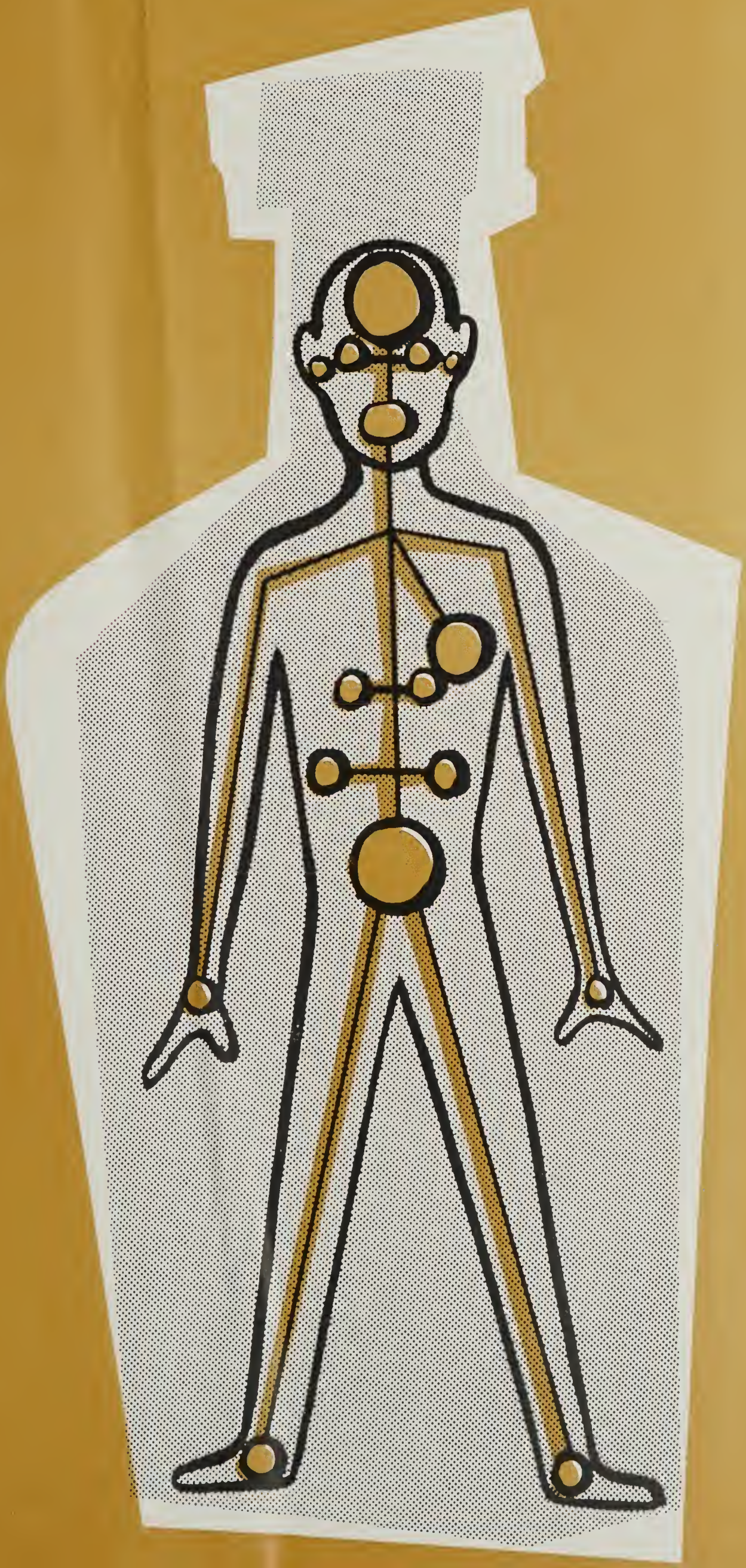
The most important effect of alcohol is on the brain.

Because most drinkers do not suffer any bad effects from their use of alcoholic beverages, many people think of alcohol as completely harmless. Others, however, look on alcohol as nothing but a poison for man, and they point to the bodily and mental disorders which some drinkers develop.

The truth of the matter is well known to scientists who have studied the subject at great length. Those who are wiling to lay aside any notions about what alcohol *ought* to do to the drinker, or any beliefs about what it ought *not* to do, can learn the scientific facts of alco-

and organs work together, in a systematic way, to do special jobs. Each organ depends on the work of the others. If one of them is damaged or disordered, the others will also suffer.

The most important effect of alcohol is on the brain. When a man goes very high up in an airplane, he is likely to "black-out"——he becomes unconscious, his mind becomes a blank. This happens because the higher one goes in the atmosphere the less oxygen there is in the air. The cells of the body all need oxygen for their work. The shortage of oxygen, high up, is felt by all the



cells. But one type of tissue is particularly sensitive to lack of this element: nerve tissue. Thus, it is the brain which suffers first and most when the man does not get enough oxygen.

Here is what would happen to a man who went higher and higher up in a plane without getting a supply of extra oxygen. First, his judgment would be damaged. Judgment depends on the highest brain center, which is the most sensitive to lack of oxygen.

Next, the man becomes unable to govern the movement of his muscles in a co-operative way. He may sway or wobble if he tries to walk. His hands may move awkwardly, and not work together as a team. His tongue and lips will stumble as he tries to talk, especially if he tries to say words he does not commonly use. The brain becomes a poorer and poorer director as it gets less and less oxygen. Its efficiency is cut down.

If the plane keeps on rising, the man will finally black out—he becomes unconscious. Finally even the brain center which controls breathing quits. Then the chest muscles no longer receive the nerve signal which keeps them moving. The man stops breathing. He now gets no oxygen at all. After a few minutes the cells of the heart fail. It stops beating, and soon the man is dead.

This illustration of what happens to a man cut off from a normal supply of oxygen is worth bearing in mind because exactly the same series of symptoms sets in when a person drinks more and more alcohol than his body can take care of at one time. After a certain amount of alcohol reaches the brain, the man's judgment becomes impaired. As more alcohol gets there, he becomes unable to organize the movements of different muscles in teamwork. This muscle disharmony becomes greater as additional alcohol reaches the brain. Finally, with still more alcohol, the man loses consciousness. And if, under certain conditions, enough added alcohol should reach his brain after he is unconscious, he may die.

Alcohol and the Brain

How does alcohol get to the brain? When a man drinks an alcoholic beverage, the alcohol passes into his blood stream, mainly through the walls of his small intestine. The circulating blood brings the alcohol to the brain, as well as to all the organs and tissues. But the strength of alcohol that reaches the different organs—the heart, liver, kidneys, brains—is very small. This is because the alcohol that the man drank is diluted hundreds of times by his blood. Here again the analogy with the man in the plane will be useful in understanding what happens.

Say a man of average size drinks 3 ounces of ordinary whiskey quickly. When diluted in his body, this will give about 0.06 per cent alcohol in the blood—that is, 6 hundredths of 1 per cent, or 6 parts alcohol to 10,000 parts blood. This is not enough to damage the tissues of heart, kidney, liver or brain, just as the shortage of oxygen is not enough to injure those organs. But this small proportion of alcohol, like the shortage of oxygen, is enough to interfere a bit with the work of the highest brain center. The result is, as in the case of the man slightly deprived of oxygen, that his judgment is impaired, he has poor muscular control, and he may lose consciousness or die.

What happens if the man does not drink so much, but just enough to become mildly or severely drunk? Or even if he drinks enough to become unconscious, but no more? Why

doesn't alcohol add up in people who drink only a little, but many times?

As alcohol circulates in the body, it is used up (oxidized) in the same way as food. A man of average weight can ordinarily use up the amount of alcohol in about an ounce of 100-proof whiskey in an hour. This produces energy which the body can use for its needs. The body, then, is working all the time to destroy the alcohol, converting it to harmless materials.

But the body can thus oxidize only a limited amount of alcohol in any given time. If alcohol is taken in at a faster rate than the body can take care of it, the un-oxidized excess accumulates in the blood stream and tissues. The amount which thus accumulates causes the disturbance in the work of the brain. After drinking stops and all that was swallowed has passed into the blood stream, the continuing oxidation steadily reduces the alcohol in the blood. Then the signs of drunkenness disappear in the reverse order of their appearance.

After the alcohol has been used up, the man will feel no effects if he drank little. If he drank a great deal so quickly as to get a large accumulation of alcohol in his blood stream, and thus became severely intoxicated, he may have hang-over signs—headaches, upset stomach, and other symptoms of illness. But after these disappear, usually in a matter of hours, the man's body is normal again. There was no permanent damage to the brain or other organs. Only the brain's ability to work efficiently was disturbed. This caused other organs to be out of order to the extent that the brain could not direct their work with efficient signals.

Alcohol acts on the brain just like an anesthetic. But it is a question of the amount that reaches the brain. The more alcohol, the stronger the effect. The efficiency of the brain is restored, in reverse order, as the body uses up the accumulated alcohol. The organs of the body suffer no permanent damage from this temporary experience.

In describing the effect of alcohol on the brain it was not possible to avoid stressing the element of drunkenness. But the great majority do not usually drink so as to get drunk. In small amounts alcohol causes only a mild sedation; this means that slight pains or fatigue cannot be felt. Alcohol does not cure them, but by its action of damping the keenness of the brain a bit, it makes the man less able to feel them. He thus feels relaxed, less tense. And this effect of small amounts of alcohol on the brain may account for most people's use of alcoholic beverages.

Other Organs

The stomach.—A small amount of alcohol, such as may be taken in one or two drinks, tends to increase the flow of juices in the stomach, and to start the mild activity of this organ which is often felt as hunger. Thus alcohol may be said to act as an appetizer. The "heartburn" felt by some who, without eating, drink a large amount of alcohol at a time, may be a sharp irritation of the stomach lining by these acid juices, lacking any food to neutralize them.

If the drink is taken as a strong alcohol solution—say 20 per cent alcohol or more, as in fortified wines or distilled spirits—the contact of the alcohol with the throat, gullet and lining of the stomach, as it first goes down, may cause an irritation, felt as a stinging or burning of these tissues. The alcohol is quickly diluted by the juices of the stomach so that the irritation stops. Some very heavy drinkers, people who often drink large amounts of strong alco-

holic beverages, have a chronic inflammation of the lining of the stomach. This gastritis may be caused by the constant irritation with strong alcohol solutions. Other organs—the liver or brain, for example—cannot be irritated this way because the alcohol is diluted, to far less than 1 per cent, before it gets to them. A large amount of alcohol in strong solution dumped suddenly into an empty stomach, especially one not used to it, may be irritating enough to cause vomiting. This reflex sometimes saves the unwise drinker from the harm of severe intoxication.

The Kidneys

The Kidneys.—In spite of all old notions, alcohol is not particularly damaging to the kidneys. It does increase their urinary activity. Recent studies indicate that this is not caused by direct action of alcohol on the kidneys but by its effect on the pituitary gland. One of the materials which it produces, and releases into the blood stream, controls the formation of urine by the kidney. As alcohol reduces the activity of this gland, the kidney forms more urine.

The Glands

The Glands.—The fact that alcohol can lessen the activity of the pituitary gland has already been mentioned. This gland influences the work of other very important glands —the thyroid and the adrenals. It inflences growth and sex development. Does the temporary suppression of a part of this activity by alcohol have any permanent damaging effect? From all the evidence of research thus far it appears that occasional drinking, or even regular drinking of small amounts of alcohol, does not cause such damage. The frequent drinking of large amounts is another matter and may be harmful to these and other glands.

From experiments with animals it has been learned that a large dose of alcohol causes the adrenal glands to discharge their secretions. These little glands, located atop the kidneys, are very important in helping man to meet the stresses and strains of life. They are known to shoot off their chemicals into the blood stream in case of sudden fright or shock, for example. Thus, the sudden intake of a large amount alcohol may be a strain, causing the adrenal glands to discharge. Again, there is no evidence that the body is impaired if this happens once in a while, since it is organized to meet such emergencies. But it is suspected that repeated severe demands on this gland over many years may exhaust its ability to work.

It used to be thought that the sex glands were especially subject to damage by alcohol. Actually, drinking alcoholic beverages cannot damage the sex glands or the seed cells. This can be understood if the manner in which alcohol reaches these tissues and cells is recalled. The alcohol first enters the blood stream and is vastly diluted. Even in severe drunkenness, the alcohol strength that reaches the glands or seed cells is not likely to be as much as ½ of 1 per cent. Yet if an alcohol solution of 1 per cent were applied directly to those tissues and cells, they would not be harmed.

The seeming stimulation of sex activity by drinking is not caused by any effect on the sex glands. It results from the action of alcohol in putting to sleep that part of the brain which controls certain kinds of behavior. Very large amounts of alcohol reduce sex activity in the same way as they lessen all activity—by making the drunken man unable to carry out planned actions, or

by putting him to sleep.

The Liver

The Liver.—In very severe intoxication, usually in a long bout of heavy drinking, the liver is likely to become swollen and tender (acute hepatitis). This might interfere temporarily with some of the important normal actions of this vital organ. The drinking of a large amount of alcohol may cause the sugar stored in the liver (as glygogen) to move out into the blood stream. It may have the same effect on other materials stored by the liver—for example, vitamin A. As far as is known these shifts of materials are not injurious. Some of them may help the body to meet the strain of intoxication—that is, to offset the effects of alcohol.

The liver is not directly irritated or injured by contact with the greatly diluted alcohol, which reaches it after even heavy drinking. The liver, in fact, plays a leading role in handling alcohol for the body. It is in this organ that the first step takes place in the change of alcohol from an intoxicating substance to harmless materials. But prolonged heavy drinking is likely to lead to serious disease.

The Water Balance.—Laboratory experiments have shown that what actually takes place in the body after drinking is not a withdrawal of water but a shift in its position. The body is about two thirds water, and about two thirds of this water is inside the cells, the rest being outside them. The amount of water outside the cells, including that of the blood, ordinarily changes little. Inside the cells the amount changes with the intake of fluids or the output of urine and sweat. When the water in the cells is reduced, thirst is felt. After a man drinks a large amount of alcohol, water moves from inside his cells to the spaces about them. This causes the feeling of thirst even though the whole body has not lost water. Whether this temporary shift in the distribution of body water has any other effect than causing thirst, is not known.

The Heart

The Heart and Circulation.—A drink of whisky may make the heart

A speaker at the recent State AA convention in Raleigh stated that he thought the explorer Christopher Columbus might very well have been a likely candidate for membership in AA. He said that he was not actually charging Columbus with being a heavy drinker, but presented this set of facts: "He left Spain and didn't know where he was going. When he got there he didn't know where he was. When he got back home, he didn't know where he had been. In addition, he had talked the Queen into hocking all her jewels so he could make the trip."

beat faster and give a sensation of warmth to the skin. This is caused by the momentary irritation of the nerve endings in the mouth, throat and gullet by the strong alcohol solution. The faster heartbeat increases the blood flow; the blood vessels near the surface of the skin become dilated, and this produces the feeling of warmth there. Actually this causes a slight loss of heat from the body.

These immediate reflex effects may raise the blood pressure a bit for a very brief time. But the general effect of a moderate sedating amount of alcohol is to cause many of the blood vessels to relax and dilate. This is followed by a slight fall in blood pressure. The increased warmth of the skin is sometimes accompanied by flushing and sweating. If a considerable amount of alcohol is consumed, the increased flow of blood to the surface may show particularly in the vessels of the eyes, which can become decidedly "bloodshot."

These short effects of a drink or two cause no lasting changes in the heart. There is no evidence that moderate amounts of alcohol cause heart disease, high blood pressure, or hardening of the arteries. Getting drunk does tax the heart and would be dangerous for a man with heart disease.

Eyes and Ears

Eyes and Ears.—The effects of alcohol on the sense organs and on their functions are many and complex. After two or three drinks, people can hear "better" than usual—for instance, they can hear softer noises than before. Their ears are more sensitive. But at the same time they are not able to discriminate as well as they could before between sounds of different intensities. The same thing occurs with vision. After a few drinks, many people can detect a smaller light than before: their eyes are more sensitive to light. But at the same time they are less able to distinguish between two different intensities of light. If a large amount is drunk, however, the ability to hear and see are simply reduced in the same way as are all actions related to the nervous system.

Alcohol and Energy

Alcohol and Energy.—As alcohol is used up in the body it is changed to various substances, one of which is acetate. This compound is formed from the oxidation of many foods, and the body uses the acetate from any source for its energy needs, for work or heat. Thus alcohol can be a source of energy for the work of muscles, and in this sense at least, it is a food. But two important facts should be remembered in this connection:

First, the amount of alcohol that the body can burn is limited, as noted before, to about ½ ounce per hour. Thus only a limited part of the energy needed for work can be supplied by alcohol.

Second, though alcohol supplies calories, it does not provide certain essential needs of the body which come in other foods—the vitamins, minerals and proteins, for instance, which come along with the calories in bread, milk, meat, fish, eggs, cereals, fruits and vegetables.

Anyone who relied on alcohol for any large part of his energy would end with some serious diseases. That, in fact, is what happens to many excessive drinkers.

Length of Life.—One question that crops up in discussions of effects of alcohol is whether drinking has an influence on how long one may live. There is no question that those who drink to excess over many years have a shorter average life span

than those who abstain or drink moderately. But what about the moderate drinkers compared to abstainers? Scientists who have carefully reviewed all the studies on this question are of the opinion that truly moderate drinkers are not different in length of life from abstainers.

Other Effects.—Research in many laboratories has shown a great variety of changes in the body with the drinking of different amounts of alcohol. For the most part, these changes take place only with large amounts. The changes are temporary. The body returns to its usual state soon after it has disposed of the alcohol. Some of the changes cause temporary impairment of the work of one or another organ. Some of these changes may be the body's way of defending itself from being hurt by the sudden presence of a large amount of alcohol.

As far as the over-all health of the body is concerned, none of these changes is important if not repeated often or allowed to go to an extreme degree. The main physical danger in drinking more than the body can oxidize within a short time is in becoming intoxicated, getting drunk. The body of the drunken man is always in danger, for its director, its brain, its safety guard, is working under a handicap—it is under an anesthetic.

Alcohol As Medicine

Thus far we have considered alcoholic beverages taken by healthy people for certain effects which they find agreeable, or because they want to go along with social customs. Some people, however, use these drinks as medicines for different ailments. Some believe a drink of one sort of another is good for their health—or even necessary for good health. Alcoholic beverages are prescribed by physicians for certain disorders, and some physicians inject alcohol directly into the blood stream of certain patients.

In popular usage, and especially for common ailments for which there are as yet no specific medicines, the taking of alcohol persists. Rum is taken for a cold. It does not cure a cold. It may, however, relieve the aches and pains, as would other analgesic drugs. Whisky is still given for snakebite. It does not counteract the venom. But it may relax the victim a bit and thus ease his pain and terror. Brandy is given to someone who has fainted. It does not work on the cause of the fainting, but helps revive the victim by its irritant action in the mouth and throat. Smelling salts do the same thing and are safer than pouring a liquid down the throat of an unconscious person. Wine is said to build blood. It may dampen the pain that goes with anemia, but the physician today has really effective treatment for that disorder.

There are certain conditions, however, for which physicians find alcohol a valuable drug making use of its special properties. One action of alcohol is to dilate some blood vessels. A drink is therefore sometimes prescribed for elderly patients suffering from hardening of the arteries. Alcohol also acts as a sedative. For the old, therefore, a drink may be prescribed as a means of getting several effects at once: dilating their blood vessels, relieving their aches, pains and feeling of chilliness, reducing their tenseness and irritability, and rousing their appetite.

Alcohol also provides calories. This quality is used to advantage by surgeons in the cases of patients who cannot be fed after an operation. The alcohol is injected slowly into a vein so that the patient receives at the same time a certain amount of

(Continued on page 30)

The Alcoholic

TWO PEOPLE

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THE first thing to strike the counselor when she greeted her new client was his look of utter dejection. All of Mr. Jackson's movements, as he pulled himself out of the chair with great effort and walked with the counselor to her office, were those characteristic of a man twenty years older than his forty years. He looked exausted. But it was more than exhaustion, the counselor thought, as Mr. Jackson sat down beside her desk. His look of tiredness was intensified by the appearance of total defeat.

With a little encouragement from the counselor, Mr. Jackson began talking about the experiences that had finally led to his seeking help at a marriage counseling agency. Nothing had gone right with him for the last six years. Like many alcoholics, he had begun drinking while he was still in his teens. At first, alcohol had seemed to help him, it had bolstered his courage so that he could face life. Gradually he drank more and more, but instead of giving him courage to face life, alcohol was making his life more difficult to accept. His marriage had reached a point where his wife would take no more. And Mr. Jackson did not blame her. How could he blame her? As he said, what woman could live with a man who had smashed three windows and the television set in a drunken rage? Why should a woman live with a

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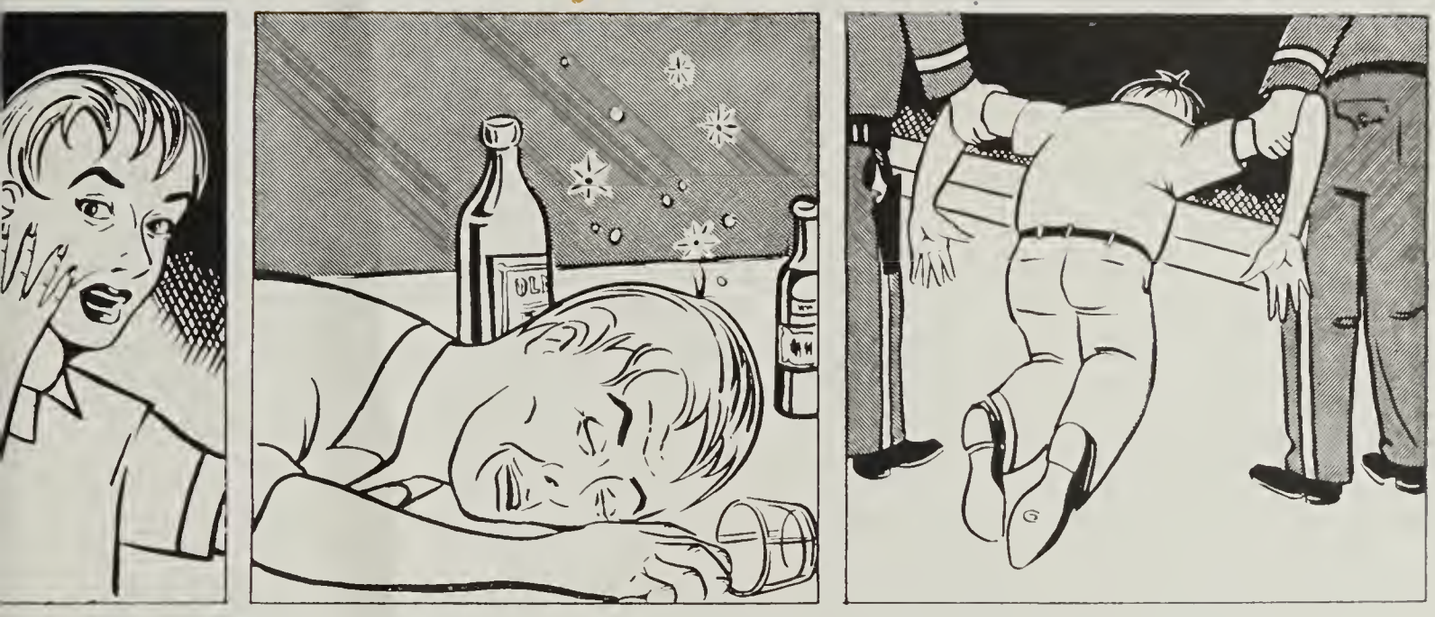
Marriage:



AND THEIR NEEDS

Strong, unmet emotional needs, present since childhood, produced conflict in the Jackson's marriage.

man who threatened not only her life but the lives of their three children? How could a woman be expected to stay with a husband who brought disgrace upon her when she had to turn to the neighbors and police for help?

In this self-derogatory view Mr. Jackson reminisced about his last drinking episode. The police took him off to jail, leaving behind him the devastation of broken glass and furniture, the trembling fright of his family, and the open disgust of the neighbors. Mr. Jackson said he had reason to feel worthless. He had done a lot of damage. If he lived to be an old man he couldn't hope to make up to his wife all the hurt he had caused her. "And the kids? I don't even deserve them," Mr. Jackson said, as he shook his head sorrowfully. He felt his life was a waste, and he alone was to blame. While he couldn't expect to salvage much out of the mess he had created, he wanted to try. He had taken his last drink. Ten days ago he had joined AA. This wasn't the first time he had tried it, but this time he was going to stick with it. His wife did not trust him though, he said ruefully. As far as she was concerned, Mr. Jackson reported, she was finished. The marriage was over. He admitted that it had not been much of a marriage for her, and he wanted help to make it a better one. That's why he was here.

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The problem Mr. Jackson brought to the counselor is not a unique nor an unfamiliar one. The public is becoming daily more aware of the alarming increase in alcoholism and its disastrous influence on marriage and family living, on community life and even on the national economy.

One of Thirty-Three

Mr. Jackson was one of thirty-three men, who with their wives came to Marriage Council of Philadelphia, Inc., for help with the combined problems of excessive drinking and marital discord. All of these men had a serious drinking problem; the wives were either non-drinkers, or, at least, were not "problem drinkers." Each of these couples had difficulties also in their marriage relationship. Marriage Council believed that there must be some relation between the excessive drinking and the marital conflict, and undertook to study troubled marriages in which the husband was an alcoholic. This was a cooperative effort. In exchange for the information about excessive drinking these couples were willing to share with the agency, Marriage Council, in an effort to relieve the marital conflict, was offering counseling service to each of the partners. Some of the couples were helped, others were not.

To illustrate a little of what has been brought out about alcoholism and its relation to marital discord, let us return to Mr. Jackson and his counselor.

In addition to hearing about some of Mr. Jackson's past experiences during the first counseling interview, the counselor arrived at certain conclusions about the kind of person Mr. Jackson was. Talking with him bore out the initial impression the counselor had received of this man. He frequently had the look of an apologetic child who appeared exceedingly grateful when his story was accepted by the counselor with kindness and understanding instead of with reproach and criticism. It was almost as though he expected to be scolded or threatened or punished. Behind his screen of fear and inadequacy and self-blame, the counselor sensed a warm, giving person reaching out for warmth in another human being, but who was always denied what he sought, withdrawing again in failure behind the screen. At the close of Mr. Jackson's interview arrangements were made for an interview with his wife, if she were willing to accept it.

Although reluctant, because, as Mrs. Jackson said, she had already suffered so much for this man, Mrs. Jackson did come to the agency. Her apathetic, withdrawn manner made it apparent to the counselor that Mrs. Jackson saw the situation as solely her husband's problem. And because it was his problem she believed their life together to be a lost cause. No matter who had tried to help him over the years, Mrs. Jackson said, her husband had become progressively worse. His efforts to change could not be trusted. He always let her down, and Mrs. Jackson had no reason to believe that this effort would be any different from the others. If Mrs. Jackson felt this way, the counselor wondered to herself, why had she come? As the interview progressed the counselor found the answer in the picture Mrs. Jackson unintentionally drew of herself. In spite of adversity she had been a faithful wife, a devoted mother and a conscientious daughter to her own mother. She was a *good* woman; a righteous, God-fearing woman, who placed great emphasis on doing "the right thing." As far as she was aware, she had left no stone unturned to help her husband. And even in her present hopelessness she could

not evade her responsibility to make this one more effort. She was already sure that he was beyond help. Mrs. Jackson still agreed to come. She was there, in body, facing the counselor, but her whole attitude made it clear that she would take part only to the extent that she would not be hurt or upset by the experience.

This description makes Mrs. Jackson sound indifferent. What the counselor saw was not an indifferent person, but a tense, highly nervous, depressed woman, totally unaware of her self-righteous attitude.

Unhappy Childhoods

These are the Jacksons as the counselor saw and felt them to be on their first visits to Marriage Council. During the weeks that followed, the counselor learned more about their experience and background. Each of them had had an unhappy childhood. Before Mr. Jackson reached school age, his father had deserted the family. Since his mother was unable to care for him and the two other children, Mr. Jackson was placed in care of a much older aunt and uncle. They acepted the charge of the boy because it was necessary, but they did not really want him. Money was always lacking which meant that in addition to living without love and the feeling of being wanted, Mr. Jackson grew up also without many of the material things in life his schoolmates took for granted. Here in his early childhood were planted the first seeds of his feelings of inadequacy, and downright fear. He never felt wanted by anyone, he never felt worthwhile. He wanted and needed someone to depend upon, but there was no one there. Life under those circumstances was too hard to take until, at an early age, he discovered a way of making life at least *look* different. By drinking he found that he could wipe out of consciousness his failures, his unworthiness, his unhappy relations with others. What was most important, drinking could alter the way he appeared to *himself*. With enough alcohol, he could *change,* from the frightened, dependent, unwanted little boy to a fighting, determined, independent man! This worked temporarily, but when the effects of the alcohol had worn off, there was the little boy, more frightened and, because of his undesirable drunken behavior, more unwanted than ever. In his use of alcohol to find within himself the man he wanted to be, Mr. Jackson merely emphasized to himself the worthlessness he believed others saw in him.

Mrs. Jackson, although not experiencing quite as extreme economic deprivation as her husband, had a background that was similar in some ways. Her mother was a domineering, exacting perfectionist who suffered through twenty years of life with an alcoholic husband. Mrs. Jackson had no loving tie with her mother, who was cold and undemonstrative. "In her way, Mrs. Jackson said, "mother loved me as much as she did the three older boys, but she never told me she loved me and she expected more of me because I was a girl." The only real love Mrs. Jackson knew was from her father and that was not a love on which she could depend. Even that one close relationship, which brought her little satisfaction because it was so unpredictable, ended abruptly when her mother left her father. Mrs. Jackson never saw her father again. Receiving nothing emotionally from her mother, and losing her undependable but affectionate father, Mrs. Jackson would not attempt giving and receiving love again. The hurt was too great. She would bury her need and pretend it didn't exist. By being totally self-sufficient she would over-

come her need to be dependent on anyone. Thus, no one could hurt her by letting her down.

Unmet Needs

These were the feelings of two teenagers when the early life of each of them had finished making its deep impression. One of them was escaping the raw deal life had dealt him by way of alcohol. The other was defending herself from life's hurts by building a barrier against getting close to anyone. Both were searching in vain for the security of being loved and wanted. Mr. Jackson was constantly faced with the disapproval of his elderly aunt and uncle, their harping criticism about his father, and with the rejection he felt from his own mother. Periodically he turned to drinking for solace. Mrs. Jackson was controlled but not loved by her mother, resenting her mother for her treatment of Mrs. Jackson's father, resenting him for depriving her of the love he could have shown, but still keeping inside of her all of her feelings of anger and hurt.

When they married Mr. Jackson was 21 and Mrs. Jackson was 19. There was no way for them to know that they were being pulled together not by love but by loneliness and their strong unmet emotional needs. In marriage, Mr. Jackson looked for the warmth of a close personal relationship. Mrs. Jackson looked for someone to depend upon. Both of them looked for the security they believed a home of their own would bring. What did they get? Mr. Jackson received the full impact of the barrier his wife unconsciously had set up against giving and receiving love. As his frustration mounted he turned more consistently to the comfort of drinking. Mrs. Jackson was faced with someone who was unable to accept adult responsibility, who was too dependent upon her to enable her to do any leaning.

Their internal conflicts were first manifested previous to marriage when an economic depression caused each to struggle for the bare necessities of life. According to Mrs. Jackson, their marriage problems began following the birth of the first child. Mrs. Jackson had not wanted any children. Her outward reason was their inadequate economic circumstances. But underneath, her reason undoubtedly was her fear of being emotionally tied to anyone, even her own child. Fate interfered with her wishes, however. Following a difficult pregnancy during which she was sick much of the time, Mrs. Jackson delivered a baby boy.

In spite of her desire not to have children, the baby filled a gap in Mrs. Jackson's life. Here was a human being who needed her desperately, who responded to attention, and yet who didn't make adult emotional demands on her. Mrs. Jackson could accept this, and she plunged into the job of m o t h e r h o o d with overwhelming conscientiousness. There were two aspects of this maternal plunge which had tremendous influence on her marriage, but of which she was totally unaware. Not having wanted her baby she was leaning over backward to give him excellent care. She had to prove to herself that she was too "good" a mother to reject her baby. Also, the care of the baby who, like his mother, was frequently sick, gave her a perfect excuse for not being able to share herself or any interests and activities with her husband. Mr. Jackson, having been shut out again, pursued his escape with increased fervor. The more irresponsible he became, the more Mrs. Jackson pulled away from him. The more she turned away, the more frustrated and unable to accept responsibility Mr. Jackson became.

Here was a man who wanted a home, approval and affection, who wanted, by belonging to someone, to shed the feelings of worthlessness carried over from a deprived childhood. He married a woman who unconsciously saw in him a similarity (his alcoholism) to her own father whom she loved but on whom she could not depend. Unlike her father her husband could not leave her. No matter how miserable a life Mrs. Jackson created for her husband by her refusal to show affection, by her criticism, disapproval and anger, he stayed in the marriage because he needed to belong somewhere. The bitterness, anger and resentment Mrs. Jackson felt were not *caused* by her husband's drinking, they were already there, the products of her own emotionally starved childhood. But his alcoholism gave her an excuse to express the hostility she had concealed—even from herself. Even a self-righteous, good woman has the right to express anger and resentment if it is justified. Mr. Jackson's drinking in the eyes of society provided the necessary justification. Similarly Mr. Jackson's drinking was not *caused* by his wife's angry, nagging rejection of him, but her behavior gave him an excuse to escape through alcohol. Here was established an interacting pattern of marriage that lasted for almost sixteen years before the couple sought help.

For a little over a year the Jacksons continued to come to Marriage Council. At first Mr. Jackson came quite regularly every week; later the intervals between visits were lengthened. In counseling he had the opportunity to unburden himself to someone who accepted him as he was, who did not nag or criticize. He began to see his alcoholism not as his only problem but as one small part of a larger problem that was his whole personality. Gradually Mr. Jackson lost his self-blame and feelings of unworthiness. He progressed in his work, developed new interests, built up confidence in himself. His three children began to look at him with new respect and Mr. Jackson responded with an increased interest in and responsibility for them. Because of the support he was feeling from the counselor he was able to continue participating in the helpful AA program. He no longer had to hunt for an escape from himself because he was beginning to like and respect the man he was.

Change in Roles

If alcoholism, as both the Jacksons at first believed, was their only problem, the marriage should have been all straightened out when he stayed sober. But it didn't happen that way. Mr. Jackson was sober, conscientious in his job, interested in his home and family, and the Jacksons continued to have difficulties. For all the years of the marriage Mrs. Jackson had had to be a responsible, dependable person. In spite of her unhappiness, she found some satisfaction in being the strong partner in this couple. This satisfaction took the place of some of the pleasures and more desirable satisfaction she had never known. Now the situation was changing. Mr. Jackson began to make decisions. He also began to realize that all that was wrong with the marriage was not his fault. Instead of alternating self-blame and apology with bouts of drunken violence, Mr. Jackson now saw himself as a married man with rights and responsibilities. He wanted to accept his responsibilities and to exert his rights. With the drinking problem out of the way, Mrs. Jackson no longer had an excuse for her husband nor for withholding affection from him. She was caught with her defenses down—and it hurt.

During the time Mr. Jackson was having regular interviews with the counselor his wife was having counseling also, but not as regularly. She began to recognize that some of the marriage problem was her fault. Correcting the situation meant looking at herself honestly and this was not easy for Mrs. Jackson. But she tried. In order to do her full share of improving the marriage she would have to change the whole attitude she had built up toward marriage, toward herself and toward the man she married. Such a complete change was not possible for her and the Jacksons had to settle for something less than they both had wanted. This is usual not only in marriage, but in any way of life. If a marriage is relieved of only part of its difficulty there is gain for the couple, for the children and for the community. Mr. Jackson achieved sobriety, Mr. and Mrs. Jackson began sharing at least a few activities, the children gained a more wholesome environment, and all of them were rewarded with a greater measure of economic security even though Mr. and Mrs. Jackson had not found real happiness.

An even more important point is illustrated by the Jacksons. The alcoholic "family man" is not living in a vacuum. His problems are closely related to the problems of those around him, particularly to those of his wife. He does not create her problems. But because of the interaction between them, each one helps to keep the other's problems in existence. Perhaps, as in this case, some women marry alcoholics, or potential alcoholics, apparently in an effort to satisfy their own emotional needs. If a woman, in her struggle for emotional survival, fosters dependence in her husband, he is made to feel inadequate as a man. If he happens to be an alcoholic he has to drink to cover up his feeling of inadequacy. The wife then has to become even more independent and responsible. This makes her resentful and critical of his behavior and it makes her husband' inadequacies stand out even more sharply as he tries to escape from the situation through alcohol. The Jacksons' difficulties undoubtedly reflect the broken homes from which they came and the economic suffering they had borne earlier. These are not the most important influences, however. Children who are hungry for love, affection and a feeling of belonging frequently come from homes in which there is wealth and from marriages which lasted even though unhappy. Regardless of social background, the alcoholic is attempting, without success unfortunately, to satisfy his need to *be* somebody in his own eyes. And quite possibly the wife of an alcoholic married him because, unconsciously, she needed to have someone dependent upon her, to prove her own worth, to justify her own feelings of bitterness and resentment, or to meet some other emotional need of which she is not aware. If you are married to an alcoholic, are you contributing to a drinking problem?

ASK an Italian "Do you drink?" and his answer is likely to be "No," although he may be drinking wine every day in the year. Call his attention to this and he patiently explains that having wine with one's meals is not "drinking", because, he tells you, wine is merely a liquid food.

—from THE COMMONSENSE BOOK OF DRINKING
By Leon D. Adams

Guidelines

(Continued from page 9)

and to unburden their worries and resentments. The family doctor can be helpful, or the clergyman, or a social worker, or a trusted friend. By attending meetings of Alcoholics Anonymous the family can get a picture of how the alcoholic himself feels about his problem. Al-Anon family groups are springing up in many communities across the country. These people—families and relatives of alcoholics—get together to help each other with their common problems. The National Council on Alcoholism, Inc., with headquarters in New York, has established local affiliated councils in 58 cities. These local groups now operate 46 Alcoholism Information Centers where people can get educational material, personal consultation, and referral to the best resources for their particular needs. Many state and local health departments and more and more hospitals are setting up facilities for the study and treatment of alcoholism. All of these are sources of guidance and information that can help the family.

Since alcoholism affects so many people, it is a health problem which deserves the intelligent attention of us all. In addition to the human waste and misery, the breakup of homes and families, none of which can be measured in dollars and cents, it has been estimated that the annual economic loss due to alcoholism runs to almost a billion dollars a year.

Some business and industrial concerns are aware of the necesity for the study and control of the alcoholism problem, and have encouraged employees who need it to seek help. Other business organizations have developed excellent programs for the treatment and rehabilitation of employees who are problem drinkers.

Those firms which have maintained alcoholism programs for reasonable lengths of time agree that such programs are well worth the effort. In the absence of alcoholism programs, co-workers and supervisors often cover up for the alcoholic in a misguided attempt to help. Moreover, fear of detection and possible dismissal keep many alcoholic employees from doing anything about their problem early when there is the best chance for recovery. Companies with alcoholism programs report that the programs more than pay for themselves in increased savings in terms of higher productivity, less waste, absenteeism, and fewer accidents and the creation of better employer-employee relationships which, in turn, lead to improved morale and greater efficiency.

Today, the nature and problems of alcoholism are better understood than ever before, and more is being learned constantly. With increased understanding and united community effort it will be possible to teach people more of the facts about alcoholism. All of us can help overcome many of the superstitions and prejudices that have been linked with alcoholism by helping to develop intelligent and constructive attitudes about it, and by working for improved treatment and rehabilitation facilities in our own communities.

Unmet Needs

(Continued from page 13)

the past as a result of his drinking are nothing compared to the serious jams he gets in now. In brief periods of half-sobriety he recognizes with mounting fear that he is in a grave condition.

This is the final phase. Unless he can afford skilled psychiatric treatment, his only hope lies in the program of Alcoholics Anonymous. Why is AA so remarkably effective in dealing with an alcoholic? As nearly as we can figure out, AA supplies three things that have been lacking all his life.

First, as he grew up with something of a vacuum in the affection department, he is singularly receptive to the veritable tidal wave of friendship which engulfs him from the moment he joins AA. At last he is in an environment where he is made to feel wanted, needed, and liked.

Feels Persecuted

Secondly, no man who subconsciously feels persecuted by fate in having been handed so many insoluble problems, can develop much of a philosophy. With no spiritual convictions whatever to sustain him, he has been forced for many years to resort to "trap doors." There are many black pits of terror in his life that must be covered. Remorse and shame make the recollection of his many wrong-doings a ceaseless agony. At the faintest suggestion of these unspeakable terrors he slams the trap door shut and stands on it. He wipes the sweat from his face and hands and realizes that he is trembling violently. But with its simple, logical, and gentle approach, AA does the job. In a matter of days or weeks, the alcoholic slowly senses a change within himself. His self-respect returns. A peace long thought impossible steals over him.

Thirdly, as all of his troubles have been caused by emotional immaturities within himself, it is easy to see that our alcoholic must grow up inside if his reprieve from this deadly illness is to be permanent. Psychiatrists will tell you that there are mighty few therapeutic techniques that can be used to mature a personality. Personally, I've heard of only one that can be applied by amateurs: people. The alcoholic is usually a neurotic and the neurotic is usually a person under the continuous curse of solitude. In AA he is thrust into a group of hearty people, friendly people, understanding people. As he gains confidence in himself, he finds the endless discussions in AA meetings perfectly wonderful. He discovers for the first time that he is genuinely concerned with the welfare of others. He spends an ever-increasing amount of time helping fellow alcoholics.

Maturing rapidly under this environment of fellowship, he outgrows his temper tantrums, his jealousies, his inability to accept authority, his suspicion of other people's motives, his cruelties, his preoccupation with fantasy. He faces reality undismayed. Sober, he walks humbly with his fellows at peace with God and man.

Alcohol and Human Body

(Continued from page 21)

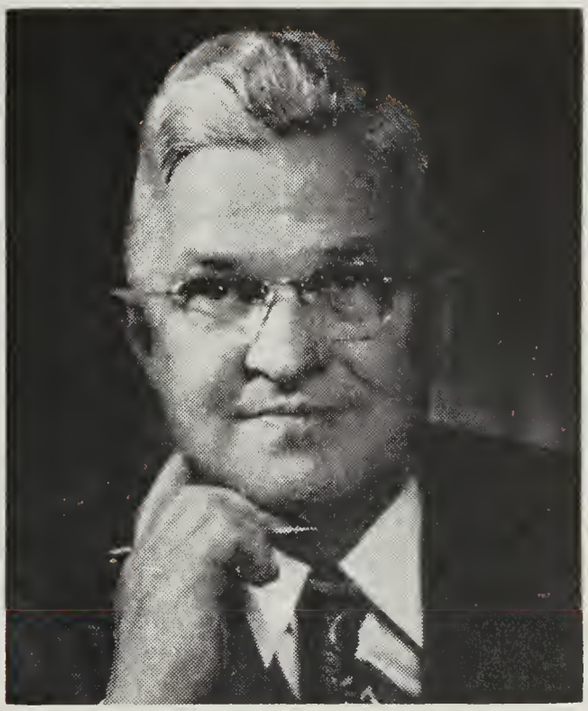
nourishment and a sedative for his pain. This use of alcohol by physicians has nothing to do with the ordinary drinking of beverages by healthy people, but it illustrates the variety of effects that alcohol exerts on the human body.

The Common Ground

(Continued from page 6)

thought and action. Today more and more church groups are holding seminars and meetings like the one mentioned above. Individual churches are conducting educational programs on alcohol and alcoholism for their members in all age groups. It is this type of action which will exercise a profound change in our past outlook towards this problem, and thereby bring about prevention of alcoholism in the future.

So whatever your denominational background, there is one thing you all have in common, the Baptist with the Episcopalian, the Presbyterian with the Catholic—the public cancer of alcoholism—a massive medical, social and spiritual problem. Where lies your role? This is certainly for you to decide, but there are some resources which might assist you in defining it that I might suggest. First of all, your church's conference, synod or diocese office will have available help, but that you probably know. Attend Alcoholics Anonymous open meetings. You will be welcome and you will discover what fine people alcoholics really are. Most of all, let's capitalize on our similarities. Discuss this problem with ministers of all denominations. The challenge is yours—with all to gain and nothing to lose.



JOHN S. RUGGLES RETIRES FOLLOWING LONG SERVICE

John S. Ruggles of Southern Pines, N. C. has retired from the N. C. Hospitals Board of Control. He was an active member of the Board and Chairman of its alcoholic committee for more than ten years.

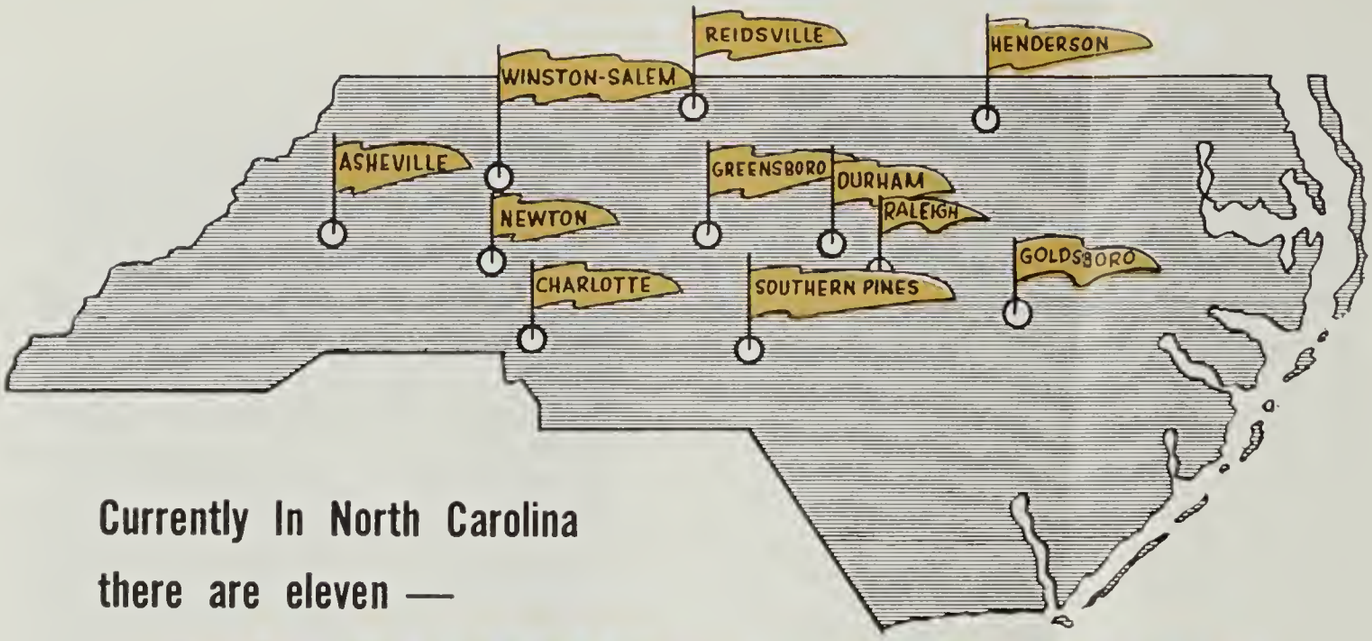
Ruggles was one of the key figures in promoting legislation establishing the Alcoholic Rehabilitation Program and laid much of the groundwork in getting the Program into operation. His interest in the ARP and his pride in its development have continued throughout the years of his service.

The Southern Pines native "retires" to a thriving insurance-realty business, several absorbing hobbies, plus a variety of community interests—including the chairmanship of the Moore County Alcoholic Education Committee.

Mr. Ruggles has the good wishes of the ARP staff as he leaves the work which has absorbed much of his time and effort during the past ten years.

IT is true that no one can predict whether one person or another will become an alcoholic. But a well-balanced, mature personality is a good form of insurance against that risk.

—Raymond G. McCarthy



Currently In North Carolina there are eleven —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—
Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program
300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—
Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JULY-AUGUST, 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

The Hospital's Place In A Program On Alcoholism

Adolescence And Alcohol

Whither State Alcoholism Programs?

Parents Can Be Bridges, Too

The Challenge Of Alcoholism

What's Brewing?

Letters To The Program

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,

compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME X NUMBER 2

JULY-AUGUST, 1960

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it. Manuscripts invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

DURHAM: At a recent meeting of the Durham Alcoholism Council, Robert S. Peake was elected Chairman of the Board, and J. Camden Hundley was named vice-chairman. New Board members are Herace W. Lewis, Judge A. R. Wilson, Rev. Barney Jones, J. C. Harris Jr., V. J. Ashbaugh Jr., J. E. Brown, and Dr. O. L. Ader.

ATLANTA, GA.: The annual homecoming for patients of the Georgian Clinic was held on June 12. Dr. John H. Venable, Director of the Georgia Department of Public Health, was a special guest for the event.

WINSTON-SALEM: Marshall C. Abee has been named Executive Director of the Forsyth County Program on Alcoholism. Mrs. Virginia O'Connell, former director of the program, will remain as social worker and a member of the rehabilitation clinic team. Dr. Richard Proctor is director of clinic services, and Mrs. Sam Seawell is program secretary.

LOS ANGELES, CALIF.: The first annual Summer School on Alcoholism will be conducted August 1-12 by the Health and Safety Department of Los Angeles State College. It is a unique educational venture in California in that it offers a two weeks' examination of alcoholism exclusively.

MINNEAPOLIS, MINN.: The Minnesota MENTAL HEALTH PROGRESS reports that six years ago there were six treatment centers for alcoholics in Minnesota, three of them state supported facilities. Today, ten resident treatment centers, including three for women, have a total bed capacity of 633 for men, 75 for women. The centers are operated by the Minnestoa Department of Public Welfare, the Hazelden Foundation, a religious organization, the Minneapolis Department of Public Welfare, and under private auspices.

RALEIGH: With summer comes summer studies on alcohol and alcoholism, and members of the ARP staff recently have traveled to various parts of the state to participate in study courses at various colleges. Alcohol workshops were held at East Carolina College in Greenville, June 7-17; North Carolina College in Durham, June 10-21; and Western Carolina College in Cullowhee, July 4-15. The sessions were under the joint sponsorship of the ARP and the three colleges participating.

BURLINGTON, N. C.: Dr. Norbert Kelly, Associate Director of the ARP, was one of the speakers featured at a recent Institute on Alcoholism held at the First Presbyterian Church. Dr. Kelly spoke on "The Sociological Approach to Alcoholism."

GREENSBORO: Mrs. Marty Mann, Executive Director of the National Council on Alcoholism, said at a recent meeting of the Greensboro Chamber of Commerce that industry must stop ignoring the problem of alcoholism. She said that some 80 major U. S. corporations have definite programs to help alcoholic employees, and that it is estimated that the rate of alcoholism in American business and industry is at least 3 per cent. That rate applies to top management as well as to assembly-line workers.

GREENSBORO: A fall meeting of the Alcoholism Programs of North Carolina is tentatively scheduled for September 21 in Greensboro.

BUTNER, N. C.: THE ARC LIGHT is the name given the newly initiated newsletter published by patients at the ARP's Butner treatment unit. Stimulus for the new publication was provided by the ARC's hard-working Recreational and Occupational Therapy Director, Sid Oakley. All the work of writing and producing THE ARC LIGHT, however, was eagerly provided by the patients themselves. The newsletter will be published monthly. Copies are to be mailed to former patients who have been treated at the ARC since January, 1960. Feature article in the first issue of ARC LIGHT announces the reunion of Butner graduates to be held at the Center on September 11, 1960. The event will be held in recognition of the 10th Anniversary of the founding of the NCARP's treatment center. All former patients of the ARC are cordially invited to be present.

CHARLOTTE, N. C.: The Health Committee of the Charlotte Chamber of Commerce has been given the go-ahead to set up a plan for locating and rehabilitating problem drinkers in local business and industry. The Chamber also created a permanent Committee on Alcoholism. Dr. William Matthews will serve as its chairman. The Reverend Joseph Kellermann, director of the Charlotte Council on Alcoholism, has been influential in these progressive developments.

LONG BEACH, CALIF.: Twelve thousand persons attended the Twenty-Fifth Anniversary Convention of Alcoholics Anonymous held here July 1-3. Only 4,000 met at the last conclave five years ago. A stirring testimonial to the growth of this unique fellowship of recovered alcoholics.

Valuable Training Aid

We would like to be placed on your mailing list to receive your bi-monthly publication, INVENTORY, for use by our instructors and students. Here at Highland View Hospital we have affiliating students on the Master, Bachelor, and Professional Student Nurse levels. We have a Post-Graduate Course for Practical Nurses and a training program for aides and orderlies. We feel that your publication will be of great value to our department.

Monica H. Hammes, R.N.
Cleveland, Ohio

Alcoholism Course For PHN's

One of our faculty has asked me to write you to inquire if the name of our library could be added to your mailing list of INVENTORY. We are including a unit on Alcoholism in Public Health Nursing in Special Services and would like to have your publication available for use by our students in this course as well as in medical nursing. If you can assist us, we shall appreciate very much your sending us this publication.

Mrs. Geraldine Mink
Cleveland, Ohio

Psychiatric Nursing Instructor

I am a clinical instructor in psychiatric nursing and find INVENTORY very helpful. May I please have my name placed on your mailing list?

Miss Dolores Gearhart
Philadelphia, Pa.

Exceptional Publication

My husband has received INVENTORY for some time and thinks it an exceptional publication. The January-February, 1960 issue is one of the most helpful ones I have read and I would appreciate it very much if you could send us an additional copy that I could give to a friend whose husband has a drinking problem.

Mrs. O. F. K.
Yakima, Washington

Tops In The Field

I have been fortunate in that I have been given four past issues of your magazine, INVENTORY. I think that without reservation it tops the field in useful information on alcoholism.

Gerald F. Wood
Marlette, Michigan

An Arrested Alcoholic

The problem of alcoholism is of great interest to me because I am an alcoholic, though an arrested one. In addition, I am interested in our local mental health committee which this year will be sponsoring a symposium about the problem drinker. For these reasons, I would find INVENTORY very helpful. If possible, I would like to receive the January-February, 1960 issue because there are several articles in it that are excellent.

Anonymous
Duluth, Minnesota

VOL. X NO. 2 INVENTORY JULY-AUGUST, 1960

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

THE HOSPITAL'S PLACE IN A PROGRAM ON ALCOHOLISM

By MARVIN A. BLOCK, M.D.

A distinguished physician explains why he believes that hospitals are obligated to care for and treat all who suffer from alcoholic illness.

THE hospital in recent years has assumed more and more importance in the community as the center for health problems. While such problems in any area are distributed among many types of agencies, both public and private, it is patent that the hospital occupies a central position in the minds of the population when it comes to questions of severe illness. In the public mind, a hospital building—the institution itself—is the hub of activity for the care of the sick. The attending physicians, nursing personnel, and administrative officers represent, to most people, the teaching authorities for all health problems in the com-

munity.

The hospital is looked upon as the center for learning about health and disease. Hospitals are the laboratories of the medical schools, where the results of didactic teaching and the lessons learned by students are applied and tested. It is here that the results of learning and accomplishment are measured. Within its walls are housed medical and surgical patients for whom all medical knowledge can be brought to bear for alleviation of their maladies.

It is no wonder, then, that the hospital occupies the important position of leadership which the public has accorded it. With this accord, however, goes a peculiar and definite responsibility on the part of its attending physicians and other personnel. It is a responsibility which requires initiative, courage, and conviction.

Unusual Position

Because of its unusual position, therefore, the hospital must be especially careful of its attitude toward disease. A patient who is sick requires care, regardless of the disease from which he suffers. Because a disease carries some connotations of opprobium, or because in the past it may have had moral implications, there is no reason for a hospital to discriminate against the patient with such disease.

In the case of alcoholism, therefore, either acute or chronic, the hospital must accept as its responsibility the treatment of humans suffering from this illness. Acute alcoholic intoxication can be, and often is, a medical emergency. As with any other medical emergency, the proper place for its treatment is in the general hospital. Any acute intoxication, regardless of the agent responsible, can have disastrous results if proper care is not administered. Regardless, then, of the agent which brings about the acute intoxication, necessary procedures, both diagnostic and laboratory, must be employed and relief given where indicated. There is no better place for such procedures than the general hospital.

There is a fallacious opinion prevalent that the care of the acutely ill alcoholic patient requires some special facility or equipment. This is not necessarily true. Any acutely intoxicated individual must have an adequate diagnosis and the treatment indicated by such diagnosis. The odor of alcohol on the breath is not always indicative of acute alcoholic intoxication. Particularly if the patient is unconscious and can give no history, it is of extreme importance that a differential diagnosis be made to determine the exact cause of unconsciousness. All too often, the odor on the breath may be a diagnostic point which can mask many other serious conditions such as a diabetic coma, cerebral hemorrhage, concussion or fracture of the skull. These more serious diagnoses may be missed because of the odor of alcohol.

Care of the acutely intoxicated individual is only one phase of the proper and complete treatment of the alcoholic who is a patient in a hospital. The available facilities must be utilized for supportive therapy after recovery of the patient from the acute phase. Such therapeutic measures are often necessary to restore good physical health to the patient.

Prolonged drinking, characteristic of alcoholic patients, often has devastating effects upon various individual organs of the body. Adequate therapeutic measures for restoring these organs to normal health must be instituted and the patient instructed so that he can continue such regime after he leaves the hospital. It is extremely common to find many physical complications associ-

ated with chronic alcoholism. These complications often reduce the physical efficiency of the patient. The patient must be taught about such impairments in his body, and how to adjust his living to insure maximum rehabilitation of the affected organs.

In the past, it has been the custom of many hospitals to dismiss the patient once he recovered from his acute intoxication. This resulted only in his return within a short time. Of course, such a revolving door program is not consistent with good therapy. The patient must be indoctrinated with proper motivation for continuation of therapy even after he has left the hospital.

This indoctrination is the responsibility of his attending physician. However, the social service department, the nursing personnel, and others associated with the treatment of the patient all have their places in stimulating such motivation. Where the patient has a private physician, it is imperative that he return to him for follow-up treatment.

Where such private physician is not available, or the patient cannot afford private care, it is the hospital's responsibility to provide adequate out-patient facilities where the patient can continue his treatment on an out-patient basis. Such clinic serves to rehabilitate the patient and help him to take his place as a responsible member of society. The same clinic in a general hospital not only follows up its patients after hospitalization, but also serves as an out-patient facility for those sick alcoholics who do not require in-patient care.

It is now recognized that the most important treatment for the chronic alcoholic comes after the acute phase of his illness. Then he is sober and capable of responding to the medical and the psychiatric treatment so necessary for successful rehabilitation.

Many general hospitals have avoided their responsibility in caring for alcoholics. Many have refused to admit patients with the diagnosis of alcoholism. A few are controlled by by-laws which specifically prohibit such admissions.

It is difficult to understand a general hospital discriminating against any sick person. It is strangely significant that many such hospitals have resorted to subterfuge for selected patients suffering from alcoholism. They are admitted with other diagnoses when there is insistence by the attending physician or someone with power and prestige in the institution.

Neither subterfuge nor discrimination should be condoned in any general hospital which serves a community. To mask the diagnosis is to mask the truth and encourage patients thus admitted in their self-delusion. It postpones the day of recognition by the patient of the serious nature of his illness. Even though the patient requests it, it is a disservice to accede to such request.

Alcoholism is said to affect 1 out of every 16 adults in our country.

Such prevalence is too great to be ignored. We cannot hope to solve so enormous a problem if responsible leaders insist upon evading it.

The American Medical Association, at its meeting in Seattle, Washington in 1956, passed a resolution urging all general hospitals in the country to admit physicians' patients suffering from alcoholism. Its House of Delegates passed this resolution unanimously.

This was a tremendous stride in the recognition of alcoholism as a disease which properly falls within the purview of medical practice. It properly places responsibility on the physician and the general hospital. It emphasizes that these patients, under their physicians' care, should be treated in a hospital setting, and that special additional facilities or equipment are not necessary for such treatment. A short time later, the American Hospital Association passed a similar resolution urging the same procedure in the case of alcoholic patients.

Anyone with considerable experience in caring for patients suffering from alcoholism will readily attest that these patients, when accepted, are as tractable and co-operative as any patient in a hospital. Untoward behavior on the part of the alcoholic patient is often an expression of resentment against the discrimination which he feels, rather than the result of the illness itself.

There are many maladies in which an untoward event may produce a situation which requires extra attention for the patient. Psychoses following parturition are not uncommon. Delirium tremens following surgery is not a rare occurrence. Post-anesthetic excitement can hardly be called a rarity in any hospital. Such temporary and often inconvenient hyperactivity on the part of an alcoholic may occur in a small percentage of cases, but as with the other conditions mentioned, it is temporary, usually of short duration, and without incident if proper treatment is instituted. Other conditions, such as diseases of the brain and the nervous system, at times may necessitate more than ordinary nursing care. When this occurs, the close attention of an extra attendant may be required. Similarly, this may occasionally happen with the alcoholic patient, but certainly not with any more frequency than with many other conditions.

Many people feel that alcoholism is a self-induced disease. I think most of us would concede that the alcoholic does not wish to be an alcoholic any more than the diabetic wishes to be a diabetic, or the coronary patient wishes to have heart trouble. The fact is that he is an extremely sick person who seeks relief from his inner tensions and problems by the most available method he knows. This may be only because he has not been taught better methods, but this is no reason to discriminate against him.

It is the responsibility of the physician, the nurses, and other hospital personnel, as well as educational institutions, to teach such people a better way of meeting their problems

than escape through alcohol.

This same sort of problem confronts people in health education when the patient suffers from diabetes or peptic ulcer. The regimes of such patients must often be modified to meet the contingencies of their illnesses. Here, too, a re-educational program is indicated.

Well Advanced

In this regard, there is some similarity to alcoholism. Unfortunately, we usually do not see the alcoholic patient until his disease is fairly well advanced. It is not surprising, therefore, that the learning process with him may be more difficult. However, if by constant vigilance we were to detect these cases earlier, much of this difficulty might be obviated. As with other diseases, the earlier detected, the better the recovery rate.

In a hospital setting, with proper history taking and examination, regardless of the admission diagnosis, many such cases could be detected sooner. A proper history will often reveal early problem drinking long before it is recognized by the patient. To call his attention to this threat before it becomes a serious problem would be doing him a tremendous service and sparing him a great deal of trouble.

The physician plays a key role in the attitude of the hospital toward the problem of alcoholism. In this day of specialization, not all physicians are particularly interested in alcoholism. However, there is no patient who provides the challenge to medicine that the alcoholic does. As a public health problem, alcoholism ranks third. With such great percentage of the population afflicted with this illness, it is reasonable that every physician in the course of his practice, no matter what his specialty, sees many of these patients frequently, though he may not be aware of it.

It is the obligation of every doctor, when he detects anything suggestive of a disease, to so advise his patient. The physician who detects in his patient the possibility of trouble with drinking should see that he is directed to the proper source for care. Every doctor should have a working knowledge of the symptomatology of alcoholism. If he does not treat such patients, he should refer them to someone who does.

It is the physician's duty to accept alcoholism as a disease which is properly within the scope of his work, and to see to it that the patient who suffers from it gets proper care. For many years, alcoholism has been a frustrating problem. Today, with the new modern drugs and techniques for treating these patients, the doctor no longer should feel this frustration. Medical literature abounds with articles on the subject and proper methods of treatment. The satisfaction derived from success with such patients is extremely rewarding. Any physician will find it well worth his effort to devote the time and energy necessary to care for these people.

How and where can a doctor learn to take care of alcoholic patients? There is no doubt that the hospital is the best place for instruction in the clinical aspects of any disease, but how can such instruction in alcoholism be carried out if these patients are not admitted to the hospital? This factor alone, if for no other reason, should be the determining one in the hospital's attitude toward the alcoholic patient. A good general hospital would not consider omitting from its curriculum for house officers or nurses any disease which affects 5,000,000 people in our country.

When the general hospital accepts these patients, and they are to be

(Continued on page 31)

Drinking is being adopted increasingly by those who are between childhood and adulthood. Why?

ADOLESCENCE AND ALCOHOL

By HOWARD E. MITCHELL, Ph.D.
PSYCHOLOGIST
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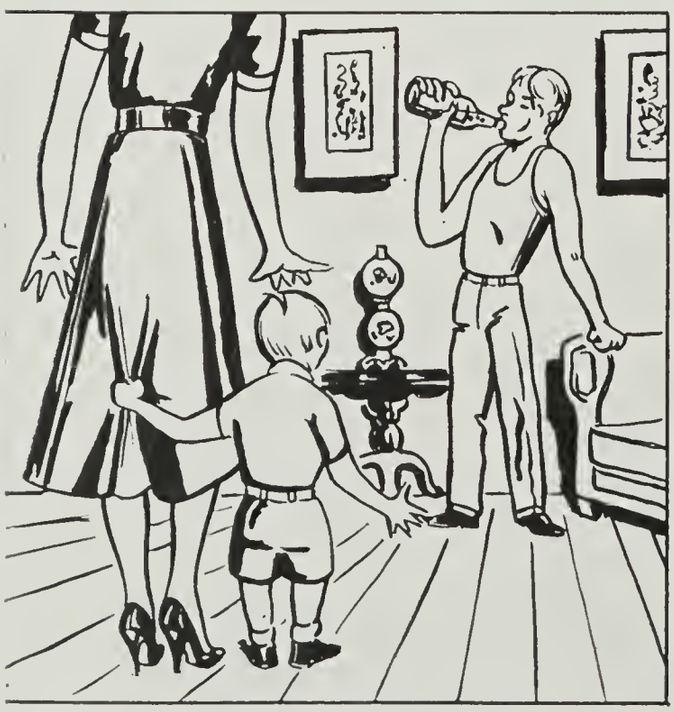
SOME significant things have been discovered recently about the onset of the use of alcohol by adolescents. The most comprehensive effort in this direction has been a study conducted by Dr. Christopher Sower, of Michigan State University. Dr. Sower, with members of the Department of Sociology and Anthropology, submitted questionnaires to 2,247 junior and senior high school students in Michigan schools, who provided information about their teenage drinking habits. These investigators found that about one third of the students reported they drink with some regularity, mostly beer or wine. Moreover, although about half the students reported drinking with their parents in the home, they felt this to be "mere tasting," not drinking. The majority of the drinking was done in a hidden manner at social functions away from adult supervision.

The heart of the matter, however, is that drinking is being adopted increasingly at the age when the individual is neither child nor adult. This is a period characterized by long thoughts, with much feeling and energy devoted to questioning adult



authority as the individual's will and ego develop. In spite of their struggle for autonomy, adolescents' drinking habits in many ways reflect those of the adults in their world.

There is growing evidence that the attitudes of adolescents toward alcohol, the values they attach to its use or rejection, are greatly determined by the specific experiences with adult models in their environment. Their decisions in this matter have less to do with factual information or advice about alcohol than we may like to think. The particular meaning that drinking has for children is to a marked degree based on what they have observed in the behavior of drinking persons.

Perhaps it can be said that in no case will a young person be attracted to alcohol unless he has had association with some older person who has received a feeling of satisfaction or tension reduction from the use of alcohol. This older person is usually a parent or some other person in a position of authority. Therefore, it seems important that we explore what meaning adult drinking models have for adolescents who tend to question adult authority and look with skepticism upon parental advice.

The important role played by parents is shown in the study entitled *Drinking in College,* by Robert Straus and Seldon D. Bacon. These investigators report that 89 per cent of the college students they sampled from homes in which both parents drink describe themselves as drinkers and that 54 per cent of those from homes where both parents abstain are abstainers. From this data Straus and Bacon conclude that "clearly parental example is an important factor in the decisions of college youth about drinking." As indicated by the Michigan study, these decisions are principally made at the "party," away from adult supervision, and are largely determined by the drinking patterns of the adult world.

Up to this point we have been thinking mainly of the family in which both parents use alcohol or abstain from its use. What happens in the home in which one parent drinks excessively and the other parent does not? What effect does such a home atmosphere have upon the resolution of the adolescent's

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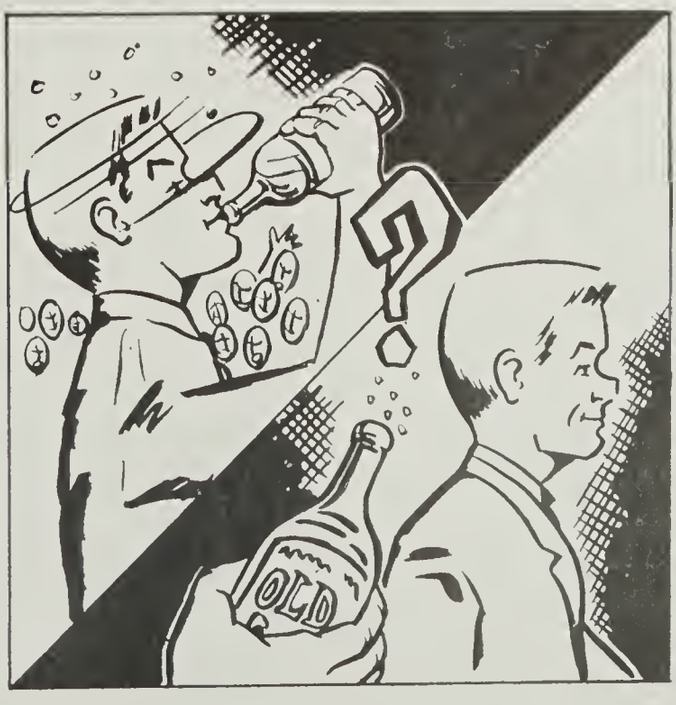

natural struggle with authority? For here the two principal authoritative figures in his world are often in violent disagreement over the one partner's drinking habits. What effect does it have upon the extent to which he may eventually be able to control not alone his intake of alcohol but any impulses that can lead to excess?

The Division of Family Study, Department of Psychiatry, School of Medicine, University of Pennsylvania. has recently been studying such families. Intensive analysis was made of the personalities of husbands who were alcoholic and of their wives who had no history of alcoholism. The character of marital conflict in these couples led us to inquire later about their relationship to and the rearing of their children, for they reported this a focal area of conflict. The case of Jim, a 17-year-old boy, is rather typical of the pattern of parent-child relationships in the couples studied.

Disappointment

Jim's father and mother had been married for eighteen years. As long as he could remember, his father had used alcohol excessively. He recalled the disappointment he felt when he didn't get his first two-wheeled bike because, his mother informed him, "the old man drank up the Christmas money again." Jim recalls that he always knew where he stood with his mother. She was firm, strongly moralistic about most issues, in fact, pretty rigid about a lot of things. He had come in conflict with the latter attitude particularly as it involved his freedom since he had been eleven or twelve years of age.

His father was variable in behavior, and this was confusing. When he was sober he was quiet, retiring, and left most of the decisions up to Jim's mother. On the other hand, whenever he had been drinking excessively, he "took over" the household. He would begin by interpreting every opinion and statement offered by Jim's mother as "nagging," and he expressed his resentment toward her domination in verbal and physical terms, especially when she threatened to call in the law or to leave.

Mother Uncomfortable

Jim recalls with considerable feeling how relieved he was when his father stopped drinking for a period lasting over four months. His father then did many things with him and around the home. During this period his mother surprisingly continued to be critical of other things about his father's behavior and frequently remarked, "It won't be long before he's back at his drinking again." The boy wondered why his mother took this attitude, not having the sophistication to recognize that perhaps she had been made uncomfortable by his father's new-found adequacy and status in the family and that she had unconscious needs to play the dominant role. In fact, one big problem for Jim seemed to be the feeling that he was caught in the middle of his parents' struggle to control and dominate each other. He recalled coming from summer camp when ten years of age, drawing himself up to his full height, 56 inches, and exploding to both of them, "I'm old enough to take care of myself now and don't need you always arguing over what I should do." He took the same attitude four years later as he prepared for his first date, and his mother lectured him about the evils of alcohol, pointing to his father as a prime example. He was tired of hearing the continued bickering between his parents, not only about his father's excessive drinking but about most other areas of family living—

financial matters, recreation, and how almost every responsibility should be met. Jim had passed through that phase of trying to discern which parent was "right," because they represented divergent models to him, and he was ready to try things on his own and without much help from them.

From this kind of home atmosphere, what can we predict Jim's reaction will be when he is offered a drink or two in his teen-age group? Of course, such predictions are not possible for even the most gifted students of human behavior, and we have no basis for saying he will develop problems around the consumption of alcohol. On the other hand, we are able to make reasonable inferences about the consequences of this situation for Jim in other respects. He has been reared in a home atmosphere filled with a generalized value conflict over many matters but focused upon his father's use of alcohol. He has witnessed his father deriving certain "satisfactions" from his drinking, in the form of relieving tension and pressure and fortifying himself to stand up to the demands placed on him by his wife. Of utmost importance to young Jim, who is struggling to develop his own self-image and will, is the fact that his father, on the one hand, is an unpredictable entity and his mother, on the other hand, an unyielding, moralizing person who consciously defends such attitudes as necessary, "since she is the only one holding the family together."

Again, there is no basis for our believing that Jim will come out of this home situation with a drinking problem. He would appear more likely to develop problems around control of his impulses in general, and problems of respect for authority, with premature attempts at independence expressed in childlike, exaggerated terms. This results from the widely divergent parent models available to him and the fact that he was denied the kind of parent-parent and parent-child relationships conducive to mature emotional development.

Our children "learn what they live," and their emotional development is enhanced by consistency between what we as parents present to them as models in our daily behavior as well as in our verbal expressions.

MUCH has been said about the role of the mother in producing greatness in the human personality, but little has been said about the role of the father. The men of this nation have made excellent use of the natural resources of their country. They have taken the coal, the oil, the metal, the wood and have accomplished amazing things. They have paid less attention to human resources. The time has long since arrived when they should take more interest in their offspring and participate more actively in their personality development.

—O. Spurgeon English, M.D.


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DIVERSIFICATION
SPECIALIZATION
STATE
ARP

Alcoholism has been treated too long in isolation. Now alcoholism programs must try to attract other scientific disciplines.

WHITHER STATE ALCOHOLISM PROGRAMS?

By DUDLEY P. MILLER, Ph.D.
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From an address by Dr. Miller before the Northeast States Conference on Alcoholism held in New Haven, Connecticut, May 18-20, 1959. Reprinted by courtesy of the Connecticut Commission on Alcoholism.

ALCOHOLISM as a physical infirmity, a psychological disorder, a social debilitation and a major health problem, is being viewed with increasing concern by the nation and the world. This concern is justified not only because of the estimated 5 million adult persons in the United States who are afflicted and the inestimable cost to the community for their management and care, but also because of the diverse and far-reaching secondary effects of this disease on other persons—wives, children, neighbors and friends—and because of the tremendous cost of supporting dependent family members. Alcoholism ramifies in its effects perhaps more widely than any other illness. Economic hardships are easily matched by psychological scars inflicted by the alcoholic on his children and spouse and by slashes in society's fabric. This disease characteristically strikes men and women during those years when they would otherwise be at the peak of their vocational productivity, when attention to their familial responsibilities is most needed, and when their richest contribution to society's religious, political, economic and educational welfare is expected. Neglect of these responsibilities costs society a tremendous toll, much of which cannot be reckoned in dollars and cents.

Although alcoholism as a focus of concern to society preceded the rise of western civilization, a significantly widespread professional interest in the problem began only about 20 years ago. This quickening of professional interest was inspired partly by the success of Alcoholics Anonymous and partly by the pioneering research work on alcoholism at Yale University in what is now known as the Yale Center of Alcohol Studies. In turn, these historical events led to the development of alcoholism

treatment, research and educational agencies under public auspices. Yet even today the extent of this new interest is largely limited to a new species of men and women who might be called "alcohologists"—people who specialize in the problems of alcoholism and the treatment of alcholics. The knowledge and experience of these specialists has reached the broad field of health workers and social scientists only to a minimal degree.

Many Disciplines

Alcoholism specialists cannot effectively attack the problems of alcoholism by themselves. The character and complexity of these problems call for the enlistment of the interests and skills of many disciplines including general physicians, psychiatrists, hospital administrators, medical schools, sociologists, anthropologists, social workers, biochemists, physiologists and educators. Alcoholism specialists have a great deal to learn from these disciplines. All of these agents need to be integrated into our field and knowledge available from them needs to be introduced into the schools of medicine, social relations, social work and public health, and into the health fabric of the total community.

Alcoholism has been treated too long as an isolated problem. A shift over into the general and broad services of health experts and health resources should be the long-range goal of alcoholism programs.

While scientific investigation into the cause, nature and treatment of alcoholism has produced much information in the last decade or two, a great deal more needs to be known before an attack on the problem can be effective on a national scale. For example, objective data concerning the prevalence of the disorder are lacking; the differences in prevalence among different cultural and ethnic groups, and particularly the reasons for these differences have been studied only superficially; the relation of alcohol use to crime, to traffic accidents and to delinquency is not known; a more precise language and classification terminology for the field is badly needed; new educational techniques are needed for specific groups at specific levels; various approaches, personnel and settings for treatment need to be carefully explored and evaluated. The question of whether all types of problem drinkers are treatable needs study as does the problem of what can and should be done for those who are unresponsive to treatment. The question of legal and social controls on alcohol and its availability to the vulnerable needs a hard look. Etiological and epidemiological studies are essential. Lastly, we need to examine carefully the problem of communication outside and within the field of alcoholism. What are various disciplines learning about how human beings react under stress? What are they learning about the techniques human beings use to combat stress and anxiety? How can this knowledge be used in the alcoholism field? How can this field transmit its knowledge and experience to other fields? To gain answers to some of these questions demands a broader concept of alcoholism than is currently evident among most of the existing specialized programs.

The member agencies of the North American Association of Alcoholism Programs were, in most instances, created and have remained as service agencies and their treatment facilities have received the major share of their resources. Consequently, these programs, although not in all cases conceived narrowly, have become narrow and circumscribed in their activities and perspectives. The

programs, including our own in Connecticut, need to be examined and encouraged to examine themselves in terms of what they are doing, for what types of patients, for how many patients, at what cost, with what effectiveness and particularly from the point of view of what they are doing about the broad problem of alcoholism.

Developments in this field may be at the crossroads. Either State programs will continue in an isolated setting, concerned only with a narrowly conceived attack on alcoholism through a program of treatment facilities and an adjunctive "shot-gun" type of educational effort or we will raise our sights toward a broader horizon and attract the interest and cooperative efforts of many other relevant disciplines and sciences from whom we have a great deal to learn.

We have been so busy concentrating on the development of specialized services and searching for people who will take a special, full-time interest in alcoholism treatment and education that we have neglected to determine the roles that other people in public and mental health areas and in the social sciences can play in our field. There is an increasing tendency for us to talk more and more among ourselves and less and less with those outside of our special area. There is a real danger that we may find ourselves on a side street while the main course of knowledge having an important bearing on alcohol problems is passing along broader avenues of activity.

Not By Specialists

In the long-term analysis, the problem of alcoholism will not be solved by a specialist organization or by any network of specialized organizations. Advances will come (1) when members of the healing professions, who are not primarily concerned with alcoholism, know enough about it to cope with it as it turns up among their patients; (2) when members of the scientific disciplines accept this problem as one worthy of their skills and attention; and (3) when educators in our public, medical, social work and public health schools realize their tremendous potential in the field and are willing to broaden and refine their techniques for teaching about physical and emotional health so as to include alcoholism.

We must, therefore, chart our course not toward the development of more specialized services but toward more diversification and toward the integration of our services within a complex of relevant disciplines and within the health fabric of the total community.

The problems of alcoholism are peculiarly germane to the broad field of public health. Alcoholism is a more representative public health problem than are psychoneuroses or functional psychoses because of the essential fact that there is, in alcoholism, a tangible pharmacological invasion of the body. It is more representative of public health problems than measles or cholera or diphtheria because essential to alcoholism is an emotional disturbance or illness which is not, etiologically speaking,

essential to predominantly physical illness. This is not to deny the physiological impact of mental illness or the psychological impact of physical illness. The structure of ideas and practices surrounding alcoholism within given cultural groups and the socialization process by which they are internalized in succeeding generations are other essential factors in the etiology of alcoholism. These three etiological factors, pharmacological agent, susceptible host and cultural behavior patterns, give alcoholism an important place among health problems in 1959. In fact, they are the basis for the belief held by a good many persons working in our field that alcoholism is one of the major—if not the major—public health problems of our time.

The field of alcoholism cries out for the interest and support of public health through the variety of disciplines making up that field which, working together, have achieved such notable success in ridding the world of many complex and baffling diseases. We need the skills, techniques and know-how of public health people as well as those of the social, cultural and biochemical sciences. Alcoholism is a problem too complex, too far-reaching, too costly and too big for a single State agency or a body of agencies in all of our States to cope with successfully. Its solution calls for the best brains within a variety of relevant disciplines.

The recognition of alcoholism as a serious problem in our society has emerged rapidly among professional and community groups and is resulting in more and more demands for action. Pressure for a serious and broad attack by responsible groups is building up. Members of State legislatures and of Congress are becoming increasingly aware of the problem. It is important to meet these pressures squarely and use them constructively before we, State and Federal agencies alike, are forced by legislative action to take steps that may be ill-advised, poorly-timed, poorly conceived and perhaps downright damaging to our progress. The response to these pressures should not be a crash program for more treatment facilities. Rather, as Dr. Leonard Duhl of the National Institute of Mental Health so ably pointed out to us at the annual meeting of the N.A.A.A.P. in 1958, we need to take a new and closer look at alcoholism as a phenomenon of ill health and at our own State programs which are striving, perhaps in the wrong direction, to combat the problem of alcoholism through their divisions of treatment, research and education.

How can we best proceed toward taking this recommended new and closer look?

In the first place it is neither necessary nor desirable that everyone whose work is to contribute to alcoholism research should be interested in alcoholism per se. In

order that adequate research may be focused on any particular goal it is necessary that a large number of people with a wide variety of relevant skills and interests be harnessed to the research chariot.

Success in these efforts will gradually shift the control, treatment and prevention of alcoholism away from the specialized agency over to the general services of the community—its public health clinics, mental health clinics, public and professional schools, members of the clergy and so on. The long-range goal of our specialized programs, then, should be to work themselves out of a job as rapidly as possible. If the general premises expressed here are accepted, then our State alcoholism programs and the N.A.A.A.P. must provide the leadership to shift the emphasis away from the specialist concept of alcoholism over to an "integrationalist" orientation.

A step toward this reorientation could be taken by changing the content of the conferences and summer schools on alcoholism that are arranged by State programs and by the N.A.A.A.P. For example, research meetings should attempt to assemble researchers both from the field of alcoholism and from a variety of disciplines outside the field, who can talk with (not to) each other and who can share knowledge through a process of cross-fertilization with emphasis on its meaning and applicability in the field of alcoholism. The first step would be a series of meetings between, let us say, physiologists and biochemists, psychiatrists and psychologists, and sociologists, anthropologists and cultural historians. All three groups would then meet jointly to discuss problems in understanding and interpretation that had arisen at the separate meetings, and to pool their findings. A final meeting would bring these three groups together with alcoholism specialists, to consider the coordination of data from the various specialties and to develop a unified approach for the field of alcoholism. Here the basic concern would be: Is coordination possible and, if so, in what terms? Similar meetings should be held with public health workers, social workers, family welfare workers and health educators, including the deans of medical schools.

N.A.A.A.P. has received a large research grant from N.I.M.H. for a 5-year project which, it is hoped, will stimulate a flow of knowledge to the field of alcoholism from other disciplines and will take a long, hard look at the field from many different vantage points. The project will, for the first time, subject the field of alcoholism to a thorough examination and attempt to discover and coordinate the responsibilities and roles of many other disciplines in this field and the contributions they can make.

The general aims of the project are: (1) to make a comprehensive study of the scientific knowledge that now exists about alcohol use and alcoholism, including relevant knowledge outside the field and its applicability to the field; (2) to inventory, study and evaluate all existing activities, programs and resources now playing an important part in attempts to solve or control the problems of alcoholism; (3) to apply the results of these studies to the formulation of policies and recommendations for improving treatment, education and prevention and to identify areas where further research is needed.

If the project succeeds only to a modest degree in achieving its aims, its work will be of inestimable value to many organizations, individuals, and groups who want to reduce the immediate and long-range effects of

(Continued on page 31)

PARENTS CAN BE BRIDGES, TOO

The best way to immunize your child against emotional illnesses like alcoholism is to route him to adulthood via a series of small foot bridges rather than insisting he take the giant span.

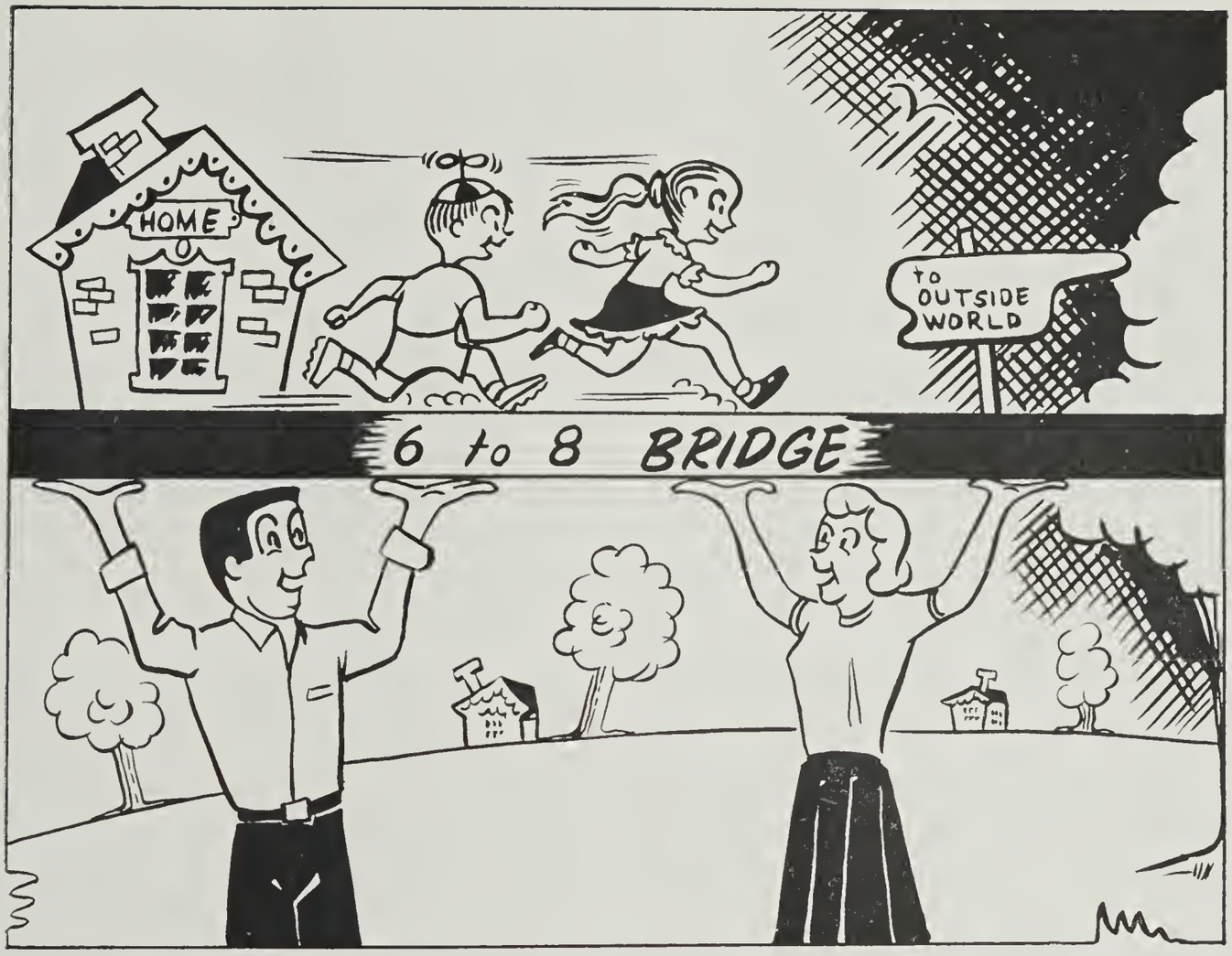
Reprinted through the courtesy of Metropolitan Life Insurance Company

SIX to eight are exciting years for a child. Even for those with some nursery school and kindergarten experience, a new world lies ahead. New friends, new experiences, new challenges, and the delightful sense of growing up—and being more independent. Life opens up a little wider every day, with each new bit of learning and accomplishment.

These are rewarding years for parents, too. It's fun to see your youngster "take a giant step"—in learning something new, or making friends all by himself. The novel experience may be anything from riding the school bus (and catching it) to paying for his school lunch. The "friend-making" may run a curious gamut at times, but he enjoys it because he does it on his own . . . and you enjoy his sharing it with you, in after-school cookies and conversations, or brief bursts of confidence just before bedtime. For the parents of the six-to-eights, these are usually shared years in a very real sense. Never before has your child had quite so much to tell you, nor the vocabulary to do it with. Later he may grow matter-of-fact, or too busy, or just generally uncommunicative about the activities and impressions he experiences in time spent away from the house.

Lots of children take to school like eager ducks to water. They want to learn, they feel important, they enjoy the decisions they must make and the challenges they must meet. They are expected to measure up . . . they feel good when they do.

Others may not adapt so readily, nor enjoy it so obviously. But for them, too, accomplishment is important, acceptance in this new bigger world just as vital. They are apt to be the "worriers"—or the shy or



timid ones, for whom even a "baby step" requires serious thought and planning . . . and a final surge of confidence and courage. With the right support, both at home and in school, they make out very well, too. They grow and do, gain the satisfactions and strengths they need. They measure up. They feel *good* when they do.

The purpose of this article is a simple one—to tell parents about some of the bridges a child crosses in the six-to-eight world . . . and a few of the ways to help. For parents can be bridges, too.

Chances are your child wouldn't even be in school today, or ready for it, if you hadn't helped him in hundreds of ways up to now. He still wants and needs your help, but now he may need a different kind.

It can be just a question of degree. He may still need quite a lot of help getting ready for school—but think it's babyish to be helped in public. Without reminders (and even with them) he may rush out excitedly to catch the school bus, or catch up with friends he walks to school with, forgetting the very lunchbox he insisted you buy the day before. Shoelaces may still defeat him, and he may lost his pennies for milk with exasperating regularity. Yet he may react fiercely to well-meant suggestions on your part about some obvious outside difficulty. In the morning rush to find rubbers and mittens you may wonder dazedly, "Who helps him find things in school?"

One answer is—no one else, quite as much. The "Lost and Found" department for the primary grades is a busy and crowded one at the beginning of school. After a few months, it slacks off surprisingly.

Children who are expected to be-

come self-reliant usually do, sooner or later. Nature's on their side, and their own growth process helps. They become *able*—they begin to notice, to hear, to learn.

Some children are helped best by parents who just stand back and let nature take its course. Some need parents who give nature a little assist from time to time—by raising standards of behavior, or by frequent reassurance. Some need even more help, and many other kinds, if they are to negotiate the bridge between home and that outside "bigger" life successfully. The growth and progress of *all* children is uneven. The better you know your child, and his place in his own age-group development, the surer your judgment can be when it comes to deciding "what to do when." So it helps to know some things about this age group in general.

Adjustment Problems

A six-to-eight is a "middle-aged" child, and being middle-aged may give him certain problems of adjustment, just as the real thing often does for adults. He is far from being a baby, but not so far that he doesn't fall back on babyish behavior at times. It's apt to be when he feels angry, frustrated, overwhelmed—or just plain tired. Teachers tell us that tantrums and toilet lapses, tears and thumb-sucking occur in the first, and even the second, grades. But they occur less and less often, particularly when the causes are taken into account—and wise, but restrained guidance and supervision exercised.

On the physical side, six to eight represents a giant step indeed. Muscular ability and coordination increase a great deal, especially in the large muscles—those of the legs, arms, and back. This helps in the playground, or in riding a bike, or making a forceful explanation of just who was first in line.

But development and coordination of the small muscles (those in the hands and eyes—the ones required for reading or writing) is slower and more uneven. It varies from child to child, and even in the same child from one day to another. Generally speaking, girls tend to be "faster" in this type of growth than boys. Their eye muscles often develop earlier than boys' . . . with the result that there's usually a difference of some months in the age at which each sex can exercise the control needed, say, for reading.

It Takes Time

Still, mastering these rather complicated new skills—reading, writing, spelling, and arithmetic—can be hard for *any* child. It takes time, and often a good deal of patience on the part of all three—teacher, child, and parent. Any child who seems to be experiencing special difficulty—who cries, rubs his forehead or his eyes frequently, or who seems inattentive or bewildered despite careful explanation and reassurance—should have both his eyes and hearing checked by an expert. Some schools provide such check-ups routinely for all students; some do not. Whenever a child seems to be taking his school work hard, it's wise to remember that some physical defect (perhaps a minor or temporary one, perhaps one requiring expert care or medical correction) may be making his school life a lot harder than it ought—or needs—to be.

Still, it's a conscientious age and not every bitten lip or furrowed brow means cause for concern in the six to eight, for this is truly an age of intensity. They can be amazingly painstaking at times. Their concentration for brief spells may be so complete they literally do not "hear" you. Their pleasure in accomplish-

ment of anything that's difficult or important to them—is just as great, and great fun to watch.

Being "on one's own" for the first time is apt to be exhilarating . . . sometimes dangerously so. Six to eights who have learned to cross streets at the corner, and only on the green light, may be a lot less careful when they're playing a spirited game of ball. But they'd have more fun and be safer in a playground or enclosed play area. And because they are away from your supervision more and more, it's only sensible to re-emphasize now and then the importance of doing things safely. This covers a variety of activities—from riding their bikes to using tools and helping around the house.

There's apt to be a good deal of hustle and bustle in the life of the average six to eight. His social life expands rapidly. He makes new friends and, besides the daily school span, he engages in more outside activities. Holidays, birthdays and birthday parties, seem to tumble over each other. Except for occasional lulls when he just has to let go—with an unpremeditated nap or an unprecedented yell—the six to eight is a busy individual indeed. By nightfall he's usually a pretty tired one.

It's quite a healthy age, too, even though your youngster may seem to experience more colds and other respiratory ills during the first year or so at school. They do "catch" more things at first, including the communicable diseases which for the most part provide immunity once they are over, but at this age they normally recover promptly . . . and gradually build up considerable resistance. Once this pleasant plateau of relatively fine health is arrived at, it's important not to forget the kinds of appointments that insure future good health—regular check-ups with the family physician and dentist.

These busy youngsters need about 12 hours of sleep, and whenever it's possible or convenient, a brief daytime nap before fatigue sets in too deeply. If an actual nap isn't practical, try to intersperse occasional periods of quiet play, or reading, or talking, especially in the late afternoon so he'll be rested and relaxed for his dinner. Sensible stress on health precautions at home will supplement that given primary graders in school.

Although there's a certain help or comfort in generalizations about children—it sometimes helps parents, for example, to realize that children vary a good deal in their ability and in their "adaptability" at different times—still every parent knows how necessary it is to particularize, too, at times. Then your special knowledge of your own child is valuable indeed.

When your child starts school, you probably "know" him better than anyone else does. And you also know him a great deal better than he knows himself. In fact, one of the exciting things school life has to offer

him is self-discovery, learning about himself as an individual, separate and distinct from his family.

Most children enjoy this new identity school affords—a place where they are no longer Mary's little brother, or Mommy's and Daddy's little girl. True, youngsters forfeit some of the favored treatment or concessions that make home so nice to come back to, but the challenge and adventure of school—and their own exciting new identity—usually outweigh these. Independence can be a delightful and heady experience. For parents the experience may be heady, but not so completely delightful. Primary graders often become remarkably bossy and contradictory at home—and make some parents feel suddenly deprived of authority, and frustrated in their efforts to "help."

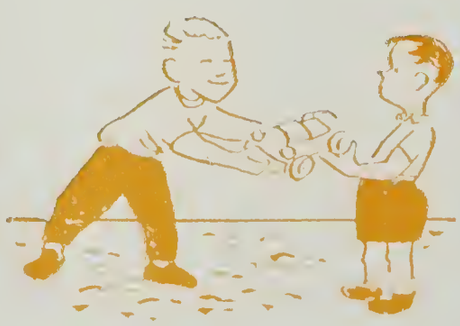
Pays Dividends

This is one of those times when your understanding—and love—of your child pays dividends. It helps to realize that he is not "resigning" from the family just because he is so eager to accept other authorities—and their ways of doing things—as well. The child who is eager to do his best, and who enjoys belonging to his group, really is affirming your love and guidance.

When he contradicts, or stamps his foot in anger and protest, or even says belligerently, "But *you* don't know," he doesn't mean it quite the way it sounds. He has found out that in his wider world other people *know* things, too. There are some new authorities in his life, ones he wants to please and be accepted by. His teacher, his new friends . . . his own school group. He can learn from them, too, and you can help him be comfortable in this important kind of learning.

Your child wants, very much, to do comfortably well in school. Even if you're a Ph.D., or a former teacher, you can help him best to do well, not by trying to "teach" him but, as a parent, by providing him with a relaxed and accepting home environment where he gets enough rest, the food and physical care and vigorous outdoor exercise his growing body needs, and a sympathetic and understanding awareness of what his outer world has become.

Your being active in school and local affairs—to the extent you can manage despite home, family, and work responsibilities—can help a lot. You learn to know the school personnel, and the special problems they deal with. If you can spare a little free time occasionally for volunteer work, you might be called on to deal with one of these problems—perhaps to support the need for a library or gym, perhaps a sudden epidemic which depletes personnel and resources, or a community plan to make up for a lack of personnel by using parents in interesting volunteer assignments. At any rate, whether you are willing to supply cookies for a parents' meeting or a grade party, or assist with an immunization program, you do get to know the school people your child comes in contact with, his classmates and *their* parents, and feel more in touch with the situation generally. This gives you an additional common bond with your child, one of activity as well as your natural interest . . . keeps you *and* your child comfortably "in the know" . . . and may give



him an added good feeling about himself to boot!

Because your child's present outside life holds so many challenges, it can be a great comfort to him if the challenges implicit in most family life—especially those involving either younger or older sisters and brothers—are kept to a minimum. Especially those which invite or imply comparisons in achievement, ability, looks, or anything else that might be worrisome—and most such comparisons are worrying to children.

In fact, it may be more helpful once in a while to dredge up one's own memories of failure and difficulty—and offer these for laugh-value, to relieve tension. You can usually wind up such an anecdote with a cheerful "And then I learned to do it!" or even a rueful, but truthful "I never did get it quite right, but I grew up anyway."

It is reassuring to children to learn that one survives, in spite of failure or embarrassment . . . and that there are many ways to succeed in life without measuring up to every outside, or preconceived, standard. One good way to communicate this sensible self-acceptance to children during the years when they question your authority is to take an easy attitude toward the whole business—perhaps to imply "We do our best in things because we want to; we don't worry ourselves to pieces if we don't do as well as *everyone* in *everything.*"

Abilities have a way of rising agreeably to the surface in such an atmosphere. Children who accept the fact that not everyone is liked by *everyone,* nor expected to do well in *everything,* usually manage to single out those they want most to be liked or admired by, and the things they want most to do. Then they can succeed in those *being* and *doing* choices, and grow on to happy and successful adulthood.

Some parents find it hard to offer their children this accepting and understanding kind of rule-of-thumb. Often it's because, as adults, they are trying to measure up to cloudy or difficult standards once set for *them.* It's not a bad idea to ask yourself occasionally: "Does my child *really* have to do this or be that? Is what seemed right for me necessarily the best for him?"

The surest way to show your child the love he needs always, and the climate he wants now to grow in during these "years of discovery" is to make it as plain as you can that you love him for *himself*—the single unduplicated individual that he is—and that you love him *no matter what.*

Children Blossom

Children are eased, and often blossom into fine accomplishment, when this is the home atmosphere that nurtures them. A lack of tension about grades and the various levels of learning or socialization gives many of them just the thing they need to be comfortable during these years, and to do well. When you are proud of *his* accomplishments, and realistic about how much progress he's making—regardless of where it stacks up on any given month or Monday—he can capitalize and make new gains, and he'll enjoy them just as much as you do in your stand-by-and-cheer position.

For even though the focus of your child's world has altered at this point (he cares about other people and other things, and you want him to), he is still strongly influenced by your feelings about him.

He is quite aware of your needs and wishes for him, even your unvoiced hopes and yearnings. He is still very close to you.

He wants to measure up. He feels good when he does.

THE CHALLENGE OF ALCOHOLISM

By MRS. MARTY MANN

EXECUTIVE DIRECTOR
NATIONAL COUNCIL ON ALCOHOLISM, INC.

Our laws still lag far behind the modern concepts of alcoholism.

WHEN the National Council on Alcoholism began its work in 1944, some of the earliest friends we had came from the general field of correction. I always knew when I went into a community that one or two judges would be involved. Very often the head of the department of corrections was interested. Most particularly, people in the parole and probation services welcomed NCA's program. As a result, a good deal has been done in this area about alcoholism. Yet, when those of us working in this field look at what still needs to be done it seems as if we had barely scratched the surface.

A major reason for this lies in the fact that humanity made a fundamental mistake a long while ago. Alcoholism for hundreds of years has been regarded, not as an illness or the disease which it is, but as a sign of badness. Its symptoms were looked upon not as deviant behavior due to an underlying illness, but as the deliberate behavior of a deviant person, somebody who is different from the rest of us, somebody who flouts the law. We thought of this condition as being self-inflicted, deliberately pursued, and held to stubbornly regardless of the damage it was doing to everyone else and even to the person himself. In short, we have thought of alcoholism for hundreds of years as strictly a moral and ethical problem. And because we thought of it in this way, there have been only two bodies that we felt

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could do anything about it. One was the Church, since it deals with morals and ethics and attempts to make them apply to everyday behavior. And the other was the Law, because it deals with people who break our mores, who flout our social customs, who will not follow the social patterns of order and discipline. For hundred of years, then, the problem of alcoholism was considered to belong to the Church and/or the Law. No one else felt it was their business, or that they could do anything about it in any case. It was hoped that the Church, the clergymen and priests, could reason with these people and could bring about a spiritual change that would stop them from doing the damage they had been doing to us and to themselves. And if this did not work then it was thought the Law had to take its course. We had to punish them, we had to put them in a safe place where presumably they would learn better.

Now these are not the two ways in which we deal with illness or disease. These are not the two social bodies that take care of this kind of problem. Certainly the Church is interested in illness and is called in frequently to comfort and even to heal. But the Law is not usually involved. People who suffer from a disease, and because of that behave in certain ways, are not normally arrested and put in jail. They are rather placed in hospitals or mental institutions—not in jails or prisons. Our laws, however, follow the belief we have held up until very recently, and so according to our laws this is all we can do in many cases with a victim of alcoholism whose behavior becomes visible, obvious, and damaging. Someday, I believe that understanding of alcoholism as a treatable disease will become widespread enough so that our laws will be changed; so that we will not treat these people any differently than we treat someone who is suffering from cancer, diabetes, tuberculosis, heart disease, or mental illness.

Alcoholism is a disease, and incidentally, although it was late as 1950, it was so officially designated by the American Medical Association in that year. Let me read you a recently published definition of alcoholism:

> A chronic disease, or disorder, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and that interferes with the drinker's health, interpersonal relations or economic functtioning.

Note that alcoholism is first "a chronic disease" and second "a disorder of behavior." It is precisely because alcoholism is a disorder of behavior that all the symptoms of alcoholism, or the bulk of them that we can recognize, are behavior symptoms. This is why we have mistaken this problem for a problem that can and should be dealt with by the Law, and have further mistaken it for something that can be handled by "correction." We have believed this behavior was willful and therefore that this person could be punished into good behavior, or argued into good behavior, or led forcibly by the hand into good behavior.

The definition called alcoholism "a chronic disease." There is another way of describing it: alcoholism is characterized by *loss of control* over drinking. This means the individual with alcoholism has lost the power of choice over whether he will drink, when he will drink, where he will drink, or how much he will drink. He has lost control. This is what alcoholism is—loss of control over

drinking. This is why simply arresting alcoholics and putting them in jail or prison, is by itself not going to do one single thing about their alcoholism. It will keep them out of trouble temporarily. It will temporarily keep them out of the hair of their particular community and the people in that community who are bothered by their behavior. But it will not do anything about the seat of the trouble which is their disease of alcholism—the fact that they have lost control over drinking.

One thing we have learned is that no alcoholic can safely touch alcohol in any form, ever. This means that the individual with alcoholism must learn to live without drinking. Now just pick anybody—regardless of whether they have broken the law and gotten into jail or prison. For anybody at all this is quite a difficult situation. Remember again that we are a drinking society. There is indeed a percentage of our adult population who do not drink by choice, from religious conviction or for other reasons, but some two-thirds of our adult population do drink: 70 to 75 million Americans. It is, therefore, a widespread and widely accepted social custom. The person who is released from jail or prison goes back into a society, most of whose members drink. Likewise the person with alcoholism who tries to stop drinking altogether finds that he or she must live in a society, most of whose members drink. The nature of alcoholism is loss of control, which means *there is no will power in this area.* It just does not work.

Incidentally, this is far from meaning that alcoholics have no will power in other areas. Quite frankly, I think they have more than the usual complement. There are very few nonalcoholics I know that would get up and go to work in the morning if they had the kind of a hangover an alcoholic has. They would be too sick. They would stay home. But the alcoholic is so fearful that someone will find out, that by an effort of will that is almost superhuman he will get up, shave, get dressed, and appear at his job. I said *at his job.*

You know, an awful lot of people thought for a very long time that the word alcoholic was synonymous with "skid row bum" or homeless man, and that this man had no job. It was thought this was the total alcoholic problem, that these were the drunks, that this was the group we had to deal with. And it was well recognized that this group was pretty difficult to deal with. They were not stable in any sense of the word; they had no permanent home, they had no family, they had no particular trade, they had no work, they drifted from place to place around the country, and they did not seem to care how they lived. They were social misfits. There were the alcoholics, we thought. Well, we have learned better. We know, for instance, from a University of Chicago study that the largest figure ever suggested for the total skid row and homeless population of the whole United States is 500,000.

Studies made by the Salvation Army and the Volunteers of America, the two major groups working with these men, indicate that *between 10 and 30 percent of their clients have alcoholism.* Taking the highest figure of 30 percent gives us 150,000 alcoholics. So this stereotype of the total problem, the skid row or homeless alcoholic, would seem to total at most 150,000 in number. But the *Quarterly Journal of Studies on Alcohol,* the only scientific journal in this field, has told us that in 1956 there were 5,015,000 alcoholics in the United States.

Over 5 million people of whom only 150,000 fitted the stereotype pic-

ture that all of us for all of our lives have accepted as the total alcoholic problem. One hundred fifty thousand is 3 percent of 5 million. Therefore, 97 percent of the victims of alcoholism in the United States do not fit the stereotype. On the contrary, they are average citizens like you and me; they do not look any different, they frequently manage to keep up a splendid facade, they are working, they are living at home, they have families. But among this group, on occasion and sometimes frequently as alcoholism progresses—for it is a progressive disease—they fall afoul of the law.

Facade Cracks

In the course of alcoholism's progression its victims begin to lose this normal status. Their facade begins to crack. It usually takes 10 to 15 years of drinking before this happens, so that it rarely becomes obvious before the individual has reached his early or mid-30's, although his alcoholism has been growing increasingly visible for a long while before then. But it has been visible only to those close to them, visible first to their families, and then to their friends, and finally to their fellow workers and employers. The first obvious happening is usually financial difficulties and job changes. They begin to move from job to job. At this same time they frequently begin to get in trouble with the law. They are picked up drunk. They spend the night in jail. Perhaps the first few times they are released and taken home, but eventually they are sentenced and they spend a longer time in jail. And finally the family has had enough and they pull out and the alcoholic is on his own. Perhaps his job drifting becomes geographical and he moves from area to area trying to get reinstated at the level in which he once was. And meanwhile he is having more and more trouble with the law and he is spending more and more time in jail. But this man is not the same as the group that make up skid row and our homeless population. This man had a background of accomplishment; he got somewhere, he was married, he had a family, he had a regular job, he had a place in the community, he was a valuable citizen until his illness began to strip him of his ability to function as a normal human being.

This is the kind of person who makes up a great proportion of the 85 to 90 percent who are in jail because of drinking. And this person we can rehabilitate because he was habilitated in the first place. There is something he can go back to. This person will respond to treatment. This person can learn to live without alcohol—if he has the proper counseling and encouragement. This person is deserving of our sympathy and our help, not of our condemnation. This person is not hopeless.

Incidentally, today we have 120 out-patient alcoholism clinics throughout the United States and the average rate of recovery in all of them is above 60 percent. This is not hopeless; it is a higher recovery rate than we have for cancer, a higher rate than we had for tuberculosis for many years. This is a high rate of recovery from any serious illness. In some of our community clinics used by business and industry, where employees of long standing are sent to the clinic by their own community, the rate is much higher—it is from 80 to 90 percent—because these men have not yet lost their status. They have not lost their jobs, or their families, or their friends, and their motivation to do something about not losing them is very high. The motivation of the man who has lost everything, or who though he may still have a family and a home, is spend-

ing more and more time in the toils of the law, does not appear to be so great, but it is if you can reach him, because *no alcoholic wants to be that way.* Do you know why? Alcoholism is the most painful disease known to man. It hurts in every department of the sufferer's life—physically, mentally, emotionally, socially and at work, and of course, financially.

Society's Fault

This is not their fault. It is ours: society's fault. We have not taught our children, or our young people, or our college students, or our adult population *which includes alcoholics,* what alcoholism is. We have not taught them that it is not a deliberate thing. We have not taught them that alcoholism means loss of control and therefore alcoholics are not to blame for their condition since they are the victims of a compulsion much bigger and stronger than they are. We have not explained that all of the alcoholics' efforts of will, and all of their determination, and all of their promises were useless from the first. We have not taught that no alcoholic can touch alcohol in any form. Because they do not know this, most alcoholics are constantly trying to drink like the other guy, to cut down, to have only one or two. So what do they think when they see this thing happening to them? They think, "I'm crazy, I'm absolutely stark staring mad. No, I can't think that, I don't dare to or I'll jump out the window or slit my throat—give me another drink and I'll stop thinking it."

Of course alcoholism hurts socially, because the social groups in which the alcoholic once moved do not want him around anymore. He is a nuisance, he makes trouble. He is not asked anywhere and people will not come to his home and pretty soon he does not have a home and he does not have friends and he is cut off from communication with his own kind. This hurts—to be an outcast, to be ostracized, to be unwanted —and this is the life of an active alcoholic.

It hurts career-wise because the alcoholic cannot work. For a long while prior to his being unable to work at all, he is working halfway. The alcoholic in the middle stage of his disease has been called the half-man. He is there in body but not in mind. His judgment is not good. His coordination is not good. He is doing a very poor job. And so career-wise it hurts because he slips down the economic scale. Or if he is an unskilled laborer, he cannot even get those kinds of jobs anymore. Naturally that makes it hurt financially. There is not any department of life in which it does not hurt acutely to be an active alcoholic. And this is why I say that alcoholics will respond, if you can get them to see they are victims of a disease over which they have no control but that they can be helped if they will accept help.

Alcoholics Anonymous

The first great proof we had of this was in the birth and growth of Alcoholics Anonymous. It has spread throughout the country and very early in the game people running jails and prisons and penitentiaries invited AA groups in. There has been a very fine record of the participation of AA in helping prisoners, parolees, and probationers. And this has shown us, if we doubt, that we can help these people. But we need much more. We need professional help too. We need psychiatric help. We need social work help. We need all kinds of psychological help, and it should be given to the people who get in the toils of the law right at the beginning. This is going to save money, and this is going to help the alcoholic.

The Hospital's Place

(Continued from page 9)

found on the medical floors along with other medical diseases, the interns and residents will have an opportunity of making adequate diagnoses and following through on treatment. Such training will serve them well when they go into private practice.

A few years of such training in general hospitals and the term "alcoholism" will no longer carry the stigma which it has had in the past. With the stigma removed, more and more physicians will become interested, not only in the diagnosis and treatment of alcoholism, but also in research into the etiology and prevention. As with many other diseases in the past, once the medical profession applied itself diligently, a solution has been found. So will it be with alcoholism when such interest is sufficiently mainfested.

Enormous Problem

The problem of alcoholism is an enormous one. It will not disappear of itself. Combating it requires the concerted efforts of all those interested. For a long time, the physician and the hospital have allowed others to care for alcoholics. Lay people have undertaken to help these sick people as best they could. Without a background of medical knowledge or therapy, they have succeeded admirably in helping these patients. Certainly it is high time that the physician recognize his responsibility in this area. He must see that hospitals establish courses for the training of their staffs in the care and treatment of these patients. This can only be done if such patients are admitted to the general hospitals with the proper diagnosis.

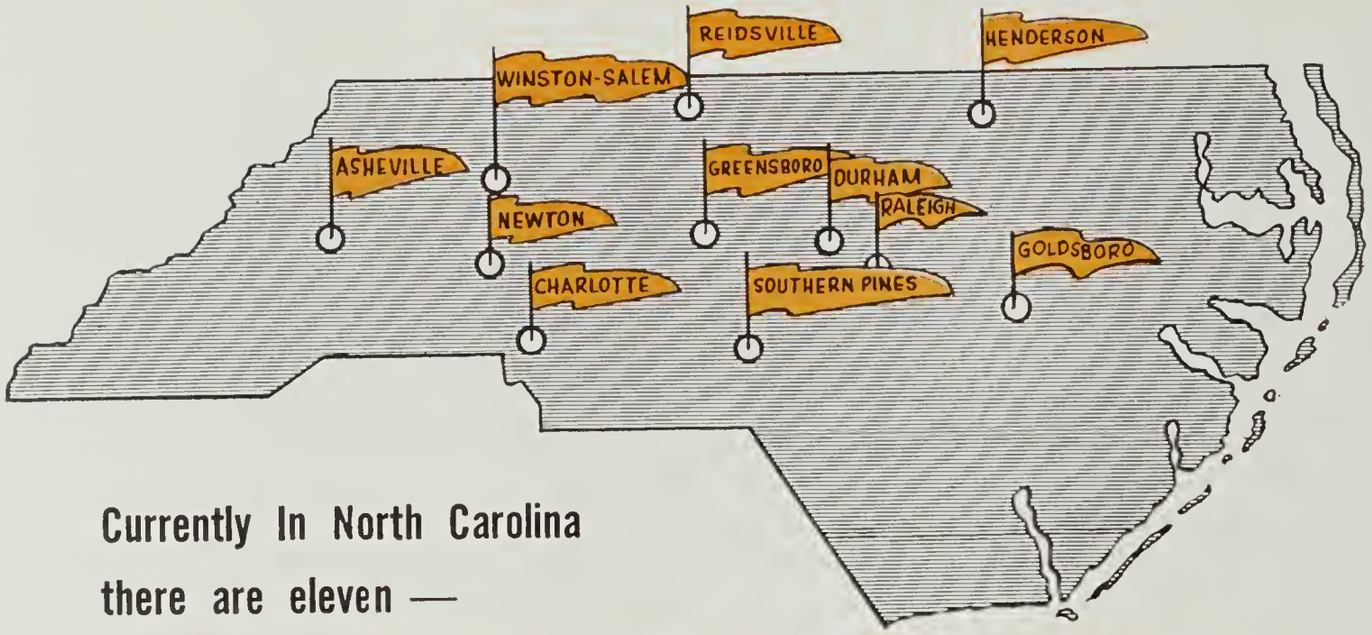
A hospital cannot and should not turn from its doors any person who is ill and requires treatment. It is also unfair to deprive the physician of the best facilities available for helping to recovery people who are suffering from any devastating illness. Both the American Medical Association and the American Hospital Association have recognized this challenge and have urged hospitals to do the same. It is a challenge from which they cannot retreat.

Whither State Alcoholism Programs?

(Continued from page 19)

alcoholism, but who lack guides which represent any considerable consensus or authority. From the information gathered and evaluated for the first time by the project, promising areas for study and research can be revealed, methods of integrating an attack on alcoholism problems into the total program of health activities can be derived and the field can perhaps be "decluttered" of much of the existing welter of misconceptions, contradictory information and misinformation.

The field of alcoholism is at a cross roads. The direction it takes from this point will depend on the leadership our State programs can bring to bear on the field and the leadership we can attract to it from the outside. A continuation of current efforts in specialized agencies and within the narrow confines of our present activities does not augur well for a healthy growth of knowledge or for realizing the potential that rests within the considerable expenditure of energy we are putting into our work.



Currently In North Carolina there are eleven —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Don Dancy, Educational Director

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—
Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program
300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—
Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem
Marshall C. Abee, Executive Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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SEPT.-OCT., 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Goals of Alcoholism Programs

The Changing Face of the A. R. C.

Recreation and the Excessive Drinker

Rehabilitating the Alcoholic Worker

Stress and What it Means to You

Letters to the Program

What's Brewing?

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

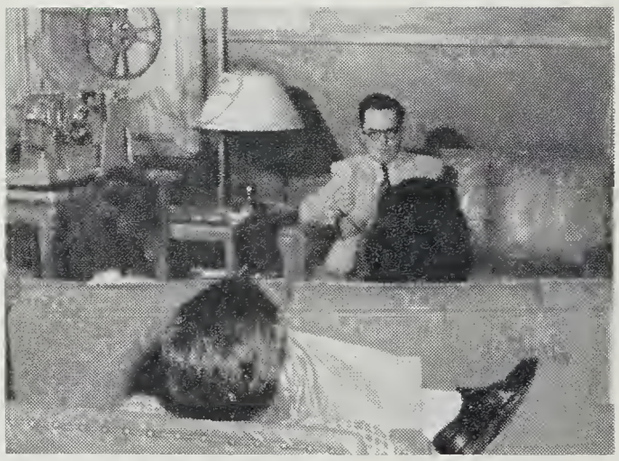
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,



compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Visiting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME X NUMBER 3

SEPTEMBER-OCTOBER, 1960

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

CAMP CAROLINE, N. C.: Members of Alcoholics Anonymous recently held their second annual AA Retreat at Camp Caroline. The weekend's activities featured panel discussions, a Sunday School service, singing, bull sessions, and, of course, endless pots of coffee.

NEW YORK CITY: The National Council on Alcoholism is planning to make Alcoholism Information Week national in scope this year. It will be observed throughout the nation from November 28 through December 2.

BURLINGTON, VERMONT: By proclamation of Governor Robert T. Stafford, the state of Vermont will take official note of AA's twenty-fifth anniversary in a week-long celebration next October. The Vermont origins of the two founders of AA, Bill and Dr. Bob, will receive special emphasis in the Governor's proclamation.

PRINCETON, NEW JERSEY: The Gallup Poll has just completed its 1960 audit of drinkers and abstainers in the adult civilian population. Some of the findings are: 1) There are approximately 64,900,000 civilian adults (62 per cent) in the country at present who, on occasion, drink alcoholic beverages—beer, wine or liquor. In 1958, the number who drank was 56,900,000—or an increase from 55 per cent to the current 62 per cent. 2) The most marked increase in the proportion of drinkers is noted among younger adults in the population. In 1958, 6 out of 10 persons between the ages of 21 and 29 said they drank alcoholic beverages. In the current audit, 7 out of 10 younger adults say they drink beer, wine or liquor on occasion. 3) There has also been a sharp increase in the proportion of women drinkers. Over half of all women interviewed by the Gallup Poll said they drank on occasion; in the 1958 audit, less than half of women said they drank. 4) An increase in the proportion of drinkers is noted at all educational levels. It is most marked, however, among those persons with high school educations. The overall proportion of drinkers today is higher than in any of the audits conducted since 1947.

BALTIMORE, MARYLAND: On May 11, 1960 Governor Tawes of Maryland announced the appointment of the State Commission on Alcoholism under the chairmanship of Dr. Lewis P. Gundry. In the bill creating the Commission, the General Assembly formally recognized alcoholism as an illness subject to treatment. It instructed the group to survey present efforts on the problem and make recommendations for improvement by January 1, 1961.

WINSTON-SALEM, N. C.: The Alcoholism Programs of North Carolina held a meeting in Winston-Salem on September 21 at the Forsyth County Court House. The Alcoholism Program of Forsyth County played hosts to the meeting. Later, staff members held an "open house" for the visitors in their attractive new offices.

NEW YORK CITY: The Christopher D. Smithers Foundation of New York City made a grant of $5,000 to the North American Association of Alcoholism Programs early in 1960. This money will be used for the publication of a statistical report on the activities in education, treatment and research on Alcoholism as carried on by our various state and provincial alcoholism organizations. Mr. R. Brinkley Smithers, President of the Foundation, is also President of the National Council on Alcoholism. The Smithers Foundation is the only operating foundation in the field of alcoholism in the United States at present.

COLUMBUS, OHIO: An alcoholism clinic at the Ohio State University Medical Center was opened just recently. In addition to a social worker, the clinic is staffed by a medical internist, a psychiatrist and clerical staff. The clinic program is geared to help the alcoholic who is still working and living with his or her family.

VANCOUVER, BRITISH COLUMBIA: The first service of its kind in Canada, a regional traveling clinic for alcoholism, recently began operation in British Columbia. The one-day, once-a-month service is designed to provide counseling and treatment to any person in the area with an alcohol problem who has a sincere desire to do something about it. The staff of the clinic comprises a medical doctor engaged by the Alcoholism Foundation of British Columbia through special arrangement of local medical groups, a counselor drawn from the present staff of the Foundation and a community liaison officer, the Foundation's director of education.

RALEIGH, N. C.: Miss Lillian Wilson has recently joined the staff of the ARP as Public Information Officer and Editor of INVENTORY. She holds a degree in sociology from the University of North Carolina and was formerly a Field Consultant and News Editor with the N. C. Tuberculosis Association. We welcome her to our ARP family and hope that her stay with us will be long and pleasant.

Great Help

Your bi-monthly publication, INVENTORY, concerned with the rehabilitation of alcoholics, has come to my attention via a Clinical Nursing Instructor at the V. A. Hospital where I am presently a Head Nurse. I believe that it would be of great help to me in my work here with my patients of the V. A. Hospital. I shall appreciate receiving INVENTORY.

Mrs. Norman R. Owen, R.N.
Salisbury, N. C.

Helpful Resource

I would like to receive INVENTORY, as it has been recommended to me very highly as a helpful resource on alcoholism.

Rev. William E. Newton
Decatur, Georgia

Excellent Magazine

I am writing to ask that you please place several of our Al-Anon members on your mailing list for INVENTORY. We think it is an excellent magazine and we find it very helpful. We appreciate the good work you are doing and the help we are receiving.

Anonymous
Elon College, N. C.

Mailing List Request

I have long enjoyed and admired your publication, INVENTORY, which I come across from time to time. Recently I heard that it would be possible to ask you to include us in your mailing list, so consider this a request for that service for which we will be most grateful.

Ruth T. Breen
Executive Director,
Jackson Council on Alcoholism
Jackson, Mississippi

Gains Understanding

Having run into one of your wonderful publications of INVENTORY, although it is a 1954 issue, and being an alcoholic and an active member of A.A., I want to say that I was able to glean from its pages a great help and further understanding of my problem. I wish you all success in your marvelous undertaking and would appreciate it if you would put me on your mailing list.

Anonymous
Alberta, Canada

Splendid Articles

Over a year ago, I admitted I was powerless over alcohol. I asked A.A. to help me and took that first step on the program. Now I can hardly believe all the wonderful things that have happened since I started on this new way of life. I am a loner, receiving help and encouragement from other alcoholics through correspondence. I was so fortunate to discover your wonderful journal, INVENTORY, which was sent to me from an A.A. member in Florida. I found the splendid articles on the alcoholic and alcoholism full of interest and so very helpful to me. I shall be very grateful if you can put my name on your mailing list.

Anonymous
Quebec, Canada

A.A. Member Writes

I have read with pleasure several issues of INVENTORY, and would be grateful if you would put me on your mailing list. I lived for many years in Durham, N. C., and attended the A.A. convention in Raleigh this past May. It is heartening, and in a very happy sense sobering, to realize that so many agencies are working so intelligently on behalf of victims of alcoholism and their families.

Anonymous
Memphis, Tenn.

Yale Graduate

At the 1960 Yale Summer School of Alcoholic Studies I became acquainted with your magazine. I am gathering material for a college course in Alcohol Education and feel your publication would be very helpful. I'd appreciate your placing my name on your mailing list.

Andrew C. Porto
New Haven, Conn.

Thanks Expressed

We have been receiving your excellent publication for the past two years, and I have intended to express our appreciation for some time. The entire A.R.P. program reflects great credit upon the people and State of North Carolina.

D. K. Andrews, Jr.
Oklahoma City, Oklahoma

Over-All Coverage

I have been given a few old copies of INVENTORY; and I want to extend my thanks for what these articles mean to me. Your over-all coverage gives so much help toward the understanding of alcohol problems.

Would you please put my name on the mailing list.

Mrs. Roy L. Monroe
Greensboro, N. C.

R.N. Writes

I am very interested in your publication, INVENTORY, and would appreciate your putting me on your mailing list. I am a Registered Nurse, and come in touch with many persons who are ill with alcoholism.

Mrs. J. O. Young, R.N.
Asheville, N. C.

Enlightening Magazine

I wish to thank you for your fine magazine. I have received it for some time now and find every issue both enlightening and enjoyable.

Bob Freitag
Willmar, Minnesota

Misses Inventory

I have had the privilege and opportunity to read INVENTORY for the past five years, but on many occasions I miss getting a copy due to my traveling and my friends sometimes fail to pass it on. I would certainly appreciate being placed on the regular mailing list of this publication, as I consider it one of the best in the United States. I would also like to take this opportunity to commend the present staff on the quality and standards of the present format and contents—a wonderful job.

Anonymous
Seattle, Washington

Pastor Writes

I find that your bi-monthly INVENTORY publication is very helpful in the area of our Church work in Christian Social Action. As conference chairman of this committee in the Congregational Christian Church, I would like to ask you to mail this pamphlet to some chairmen in local churches in order that they too might receive the benefit of it.

Rev. L. Gale Brady
Henderson, N. C.

TENTH ANNIVERSARY

The Changing Face Of The A.R.C.

ON September 1, 1950, the North Carolina Alcoholic Rehabilitation Center at Butner, N. C. received its first patient. Now, ten years and 3,500 patients later, the State Rehabilitation Center for alcoholics is celebrating its tenth anniversary.

To commemorate this occasion, Dr. Donald Macdonald, Medical Director of the treatment center, issued invitations to all former patients and their families to attend an Open House on Butner's first Homecoming Day—Sunday, September 11, 1960.

The news that Hurricane Donna was headed our way brought fears that inclement weather might keep some persons away who otherwise might have come. However, the light rain which fell during the afternoon did not dampen the Homecoming spirit.

From all over the state they came . . . farmers and real estate agents, housewives and grocers. It was more like a college class reunion than anything else. Old friends greeting each other, talking over old times, bringing each other up to date on what had happened in the past few months or years . . . the crowd singing around the piano . . . the little groups engaged in friendly chatter over cups of coffee. It was a happy occasion.

Interviews Held

During interviews with staff members that afternoon, the former patients told of their appreciation for the help they had received at Butner. They spoke very frankly about the slips they had sometimes experienced since leaving the treatment center; the sources they had turned to for help at difficult times; proudly related the exact number of months or years of sobriety; and talked freely about their attitudes and general mental and physical health. Most of all, they seemed appreciative that Butner had helped them get started again. In the words of one former patient, "Butner set me straight; it helped my way of thinking about so

many things."

For those who are an integral part of the treatment team at Butner and deal directly with the patients who come there for help, and for others who reach the patients indirectly, the news was gratifying to hear. These people had found help for their illness. Their returning on this Homecoming Day was evidence of their interest and appreciation.

A state-supported facility, the in-patient treatment center is located fifteen miles northeast of Durham, N. C. It is operated by the N. C. Alcoholic Rehabilitation Program under the Hospitals Board of Control. Dr. Donald Macdonald, a psychiatrist, and Dr. Norbert L. Kelly, a sociologist, share co-directorship of the program. White male and female patients, who are admitted on a voluntary basis, receive 28 days of treatment consisting of group psychotherapy, discussions led by clinical personnel, educational films and individual consultations with the clinical staff.

Changes Noted

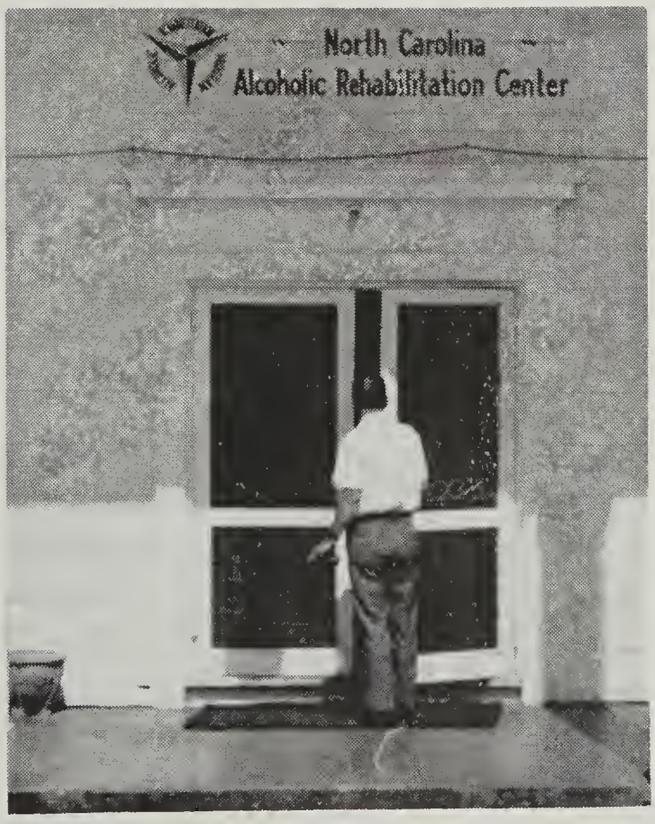
These past ten years have reflected Butner's growth in several ways. From its first staff consisting of a part-time medical director, two psychologists, two occupational therapists and several attendants, Butner's treatment program has grown to include a full-time medical director, a second physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, an occupational therapist-recreation director and a full attendant staff. Patients no longer are required to be admitted through the John Umstead State Hospital, but are admitted directly to the treatment center, in response to written or telephone application for an appointment with the Medical Director.

Other significant changes relate to the treatment process itself. Much more attention is given now to the individual patient and his special problems than has been the case in past years. When a patient arrives at Butner, he or she is assigned a particular staff member who acts as the individual's personal counselor throughout the duration of his stay. In this way, counselor and patient have a chance to get to know one another, thus providing a stimulus for mutual confidence and trust. In addition, the number of group therapy sessions have been increased, and because there are fewer individuals in each group, there is greater opportunity for wider participation and self-expression.

Treatment And Growth

Yes, this is Butner's tenth anniversary. Ten years of treatment and ten years of growth.

At this time, *Inventory* would like to introduce to you the staff members of the Alcoholic Treatment Center at Butner. (J.R.)



Come in and visit the A. R. C.

A WARM SMILE AND A FRIENDLY HANDSHAKE

Mr. and Mrs. E C. Keith

SUPERVISING ATTENDANTS

THE attendants at the Butner Treatment Center are usually the first persons on the staff to greet the patients when they arrive and the last to bid them farewell upon their departure.

Realizing that many alcoholics harbor feelings of anxiety and apprehension upon their arrival at Butner, we do our best to make them feel welcome. Some wonder what kind of place it will be, what kind of treatment for their problem they will receive, and if they will actually be helped during these four weeks. For these reasons, they need to feel that Butner is a friendly place—a place where there are staff members who are genuinely interested in the well-being of each and every patient. A warm smile and a friendly handshake can do much to establish a "homey" atmosphere.

When a patient arrives at the Center, we greet him at the door and show him his living quarters. We explain to him rules and regulations and attempt to answer any questions he might ask. Later, we tour the building, pausing to see the kitchen, dining room, the lobby with its recreation facilities and the occupational therapy shop.

Attendants are responsible for giving medications and attending to other medicinal needs of the patients such as taking blood pressure and laboratory specimens. In addition, we keep weight charts for the patients, maintain a doctor's order book, a daily drug book and a daily report book. We keep an individual folder on each patient noting all the special treatment he receives while at the Center.

Since we spend a great deal of time with the patients during their stay at Butner, our relationship with them is a friendly one. The frequent games of softball, table tennis and cards supply many hours of fun. All of this, we feel, is a helpful part of the treatment program.

(Continued on page 28)

CAPTAIN OF THE TEAM

Donald E. Macdonald, M.D.

MEDICAL DIRECTOR

IT is not difficult for the casual visitor to the Alcoholic Rehabilitation Center to form a fairly accurate impression of the daily activities which comprise the treatment program. A half-hour tour of the building is enough time in which to observe the "junior" and "senior" group psychotherapy discussions in progress, the dining room being prepared for the mid-day meal, the well-equipped occupational therapy shop, the secretaries busy in the record room, and other staff members at work in their offices.

What may not be so apparent at first glance is the considerable amount of time which must be devoted to "behind-the-scenes" planning and organization, not only in order to maintain the smooth running of the Center but in order to incorporate new and improved treatment methods in our program. Plans for future development and possible extension of our program, for example, to provide outpatient treatment services for our patients, must be made months and sometimes years in advance, involving such matters as availability of suitable premises and the recruitment of professional staff. Again, our present buildings require maintenance and at times some degree of renovation; furnishings wear out and have to be replaced; office accommodation must be found for new staff members; all these changes must be anticipated ahead of time and carried out with minimum disruption of the treatment program.

Members of the Center staff meet at frequent intervals to discuss not only the day by day progress of the rehabilitation program with reference to particular patients, but also the underlying psychiatric principles of the program and the ultimate goals of treatment. It is the responsibility of the Medical Director also to ensure that the professional skills of the various members of the staff are utilized in the most appropriate and economical ways for the benefit of the patient, with no unnecessary and

(Continued on page 29)

UNDERSTANDING THE PATIENT

Janet Haas

CLINICAL PSYCHOLOGIST

IN the areas of diagnostic testing, psychotherapy and research, the clinical psychologist works together with other members of the staff as part of the therapeutic team. It is only by a close and harmonious collaboration that the welfare of the patient may be fully realized.

One of the chief functions of the psychologist at the Butner treatment center is that of assisting other members of the staff in understanding the individual patient through the use of psychological testing. We do not regard our patients as an homogeneous group simply because they all show the same response to emotional stress, i.e., alcoholism. On the contrary, we know that we are dealing with individual men and women who, like us, are faced with human joys and sorrows, and human hopes and disappointments each day in their struggle to become more productive, more comfortable, more free from anxiety. Psychological testing can assist us by revealing an individual's intellectual level and functioning, his method of organizing his work, his attitude toward recreation and achievement, love and anger, and a host of other factors which are involved in the process of understanding a fellow human being.

There are many techniques which can be utilized toward the end of furthering understanding of our patients. These include questionnaires, drawings and the interpretation of pictures or ink blots which are sufficiently vague to allow one to respond to them in an almost infinite variety of ways. Through the choice of the most appropriate and efficient techniques, the psychologist is able to present to the staff material which will further the treatment process.

Increasingly, the role of the psychologist has grown to include direct participation in psychotherapy. At the Alcoholic Rehabilitation Center the clinical psychologist participates on both a group and an individual basis.

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MY CONTRIBUTION IS A 'SOCIAL DIAGNOSIS'

Roberta F. Lytle

PSYCHIATRIC SOCIAL WORKER

I BELONG to the profession of social work, which, like medicine, nursing, and the ministry, is considered to be one of the "helping" professions. Like the others, our work is with people whose lives have become troubled and unmanageable, and have come to us for help. To deal adequately with the complex and varied problems of human beings, the social worker, like the doctor and the nurse, cannot afford to "play it by ear" but must be prepared by careful training to assume the exacting responsibilities which are his. Therefore, today's trained social worker has attended and received a Masters degree from a fully accredited graduate School of Social Work. He considers his client's (or patient's) confidences as inviolate. He values each troubled person as a unique human being, whose difficulties must be seen in the light of their meaning to the sufferer, and not in accordance with the values, experiences, or prejudices of others. He accepts this person as he is, and helps him to an understanding of himself and his problems. By establishing in an atmosphere of acceptance a relationship of confidence and trust, the psychiatric social worker makes it possible for the patient to first reveal himself and later to re-evaluate himself and his problems.

At the Alcoholic Rehabilitation Center, where I find twenty-eight days only too short a time in which to help my patients clarify their thinking, I am happy to be a member of a therapeutic team with which I can share the responsibility and upon whose judgment I can rely for help in formulating a diagnosis of my patients' needs. My contribution is a "social diagnosis", a summing up of my patient's problems in terms of his life experience, his relationships to his family, friends, and other important phases of his environment such as his church, his job and his recreation. It is my hope that the patient will gain a new perspective of himself, not only through our private interviews, but as a result of the group therapy

(Continued on page 30)

VOCATIONAL GUIDANCE DIRECTOR

SINCE man's economic, social and psychological needs are all affected to some degree by his job performance and status, this is a key area in the life of the average American citizen—including the alcoholic.

It is true that not all alcoholics who are admitted to the Butner treatment center have problems in relation to their occupations in the working world. But many of them do, and these problems may be related to the individual's alcoholism.

For these reasons, it seems necessary that a treatment center for alcoholics have on its staff a person whose responsibility it is to counsel with the patients regarding their occupations and related problems. This responsibility falls to the vocational guidance director.

Sometime during the patient's stay at Butner, the director interviews him concerning his job situation, if the patient is presently employed. The patient may be having difficulty in adjusting to his present position, and might be having problems with his relationship to his supervisor; working conditions may be unsatisfactory; or perhaps he thinks he has been shouldered with too many responsibilities. The guidance counselor helps the patient to plan, in a constructive manner, ways and means of correcting many of these problems which exist. He may also discuss with the patient the possibility of a job change, if satisfactory adjustment to the situation seems unfeasible.

In counseling with patients who are not employed at the time they enter our treatment center, the vocational guidance director discusses the patient's primary interests, his capabilities, his likes and dislikes. He often contacts former employers to see if they might possibly reinstate the patient in his former position after he leaves the Center, providing the patient agrees to this. The counselor also works very closely with the North

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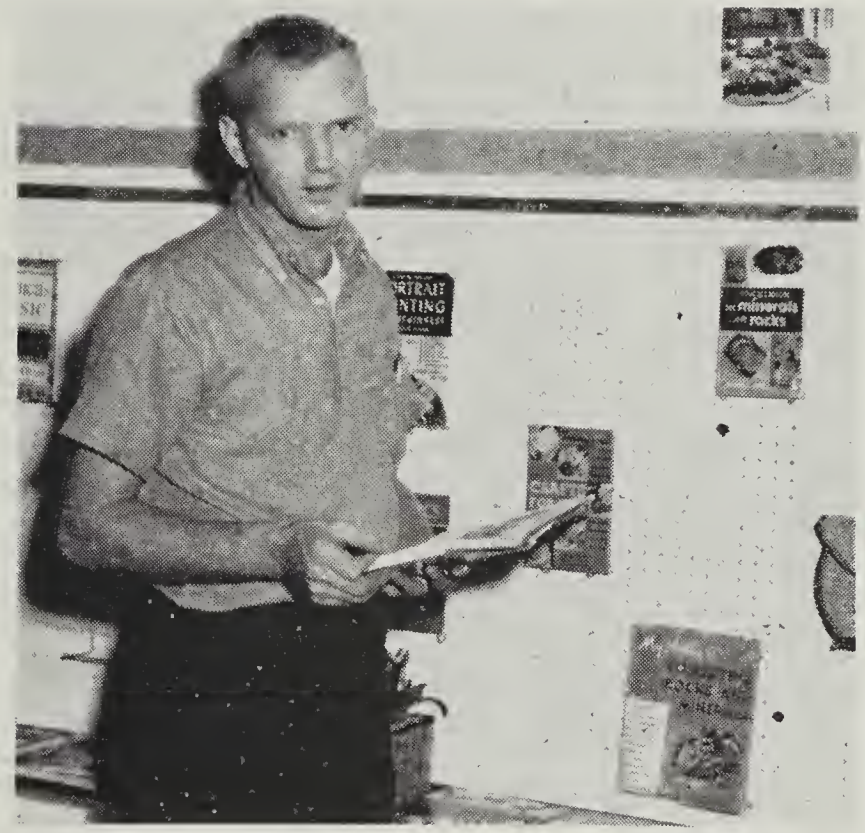


RELEASE OF TENSIONS THROUGH RECREATION

Sidney Oakley

RECREATION AND OCCUPATIONAL THERAPIST

EVERY year in the United States billions of dollars are spent on recreation. Because of the age of automation and shorter working hours, there is more time for leisure now than ever before. Thus recreation is on the grow—all kinds of recreation: swimming and boating; traveling and camping; sketching and painting.

And recreation is **good** for people. It affords them much-needed outlets for release of their tensions, for use of their creative abilities, and for fun. Recreation is a good way to let go.

We on the staff of the Butner treatment center believe that recreation is a very important part of the patients' treatment during their stay here with us. We feel that if we can stimulate some interest in activities which will carry over into the patients' lives after they return home, then we have given them something worthwhile.

The recreation/occupational therapist serves as organizer and coordinator of recreation activities at Butner. When a patient arrives at the Center, the therapist must familiarize himself with the patient's social history—with his economic status, his educational level, his religious preference, and his physical and mental abilities, for all of these factors will influence the type of recreation which the patient will enjoy and from which he will receive a greater or lesser amount of satisfaction.

In several cases the patient has not had or availed himself of the opportunity to engage in many forms of recreation, or to acquire the necessary skills for performing and enjoying these activities. Naturally, he will not want to participate in those activities which he has never cared for. Thus the recreator must offer outlets in a variety of fields: arts and crafts, music, dance, drama, sports and games, hobbies and outing activities. He attempts to arouse the interest of the patients by means of demonstra-

(Continued on page 29)

RECREATION and the EXCESSIVE DRINKER

BY DOUGLAS H. SESSOMS, PH.D.

Recreation can be a force in the prevention of chronic drinking.

RECREATION in the United States is big business! Our fun bill in 1958 was in excess of 41 billion dollars. Of this amount, two billion was spent for travel and 9.2 billion for alcohol.

For the sixty million Americans who drink, the consumption of alcoholic beverages is a part of their leisure. What could be more American, they say, than to have a can of beer at a ball game, a martini with a friend after work, or a glass of champagne at a wedding? Social drinking and social recreation are often interrelated. Knowing how to drink is as necessary for the social drinker as knowing how to swing a golf club is to the golfer. Drinking, however, does not make up the social experience any more than swinging a golf club constitutes playing golf. Nor does one have to drink in order to enjoy athletics. Unfortunately for many, however, drinking is more than a social skill or a part of a leisure experience; it is a single use of time—a way of recreation in itself.

This is not meant to imply that excessive drinking stems solely from the mono-leisure skill and recreation illiteracy of the participant, nor that a balanced diet of leisure pursuits would prevent chronic drinking and alcoholism. Alcoholism and chronic drinking are far more complex than that, but there may be something in one's leisure use which makes him more vulnerable to these illnesses.

Recreation affords many opportunities for the expression of self. It provides a natural outlet for creative urges. It serves as an avenue for the release of tensions, of expelling pent-up emotions and energies. It stimulates socialization, competition and cooperativeness. It serves as a last frontier of individualism. With the growth of automation, routine procedures and piecemeal tasks, leisure has been recognized as a primary time for the fulfilling of these desires. The importance of recreation in modern life cannot be over stated.

Recreation takes many forms, some of which are more fruitful as avenues of creation than others. Certainly sketching allows for more expression of self than does painting certain numbers designated colors, yet both are forms of art. Some

Dr. Sessoms is an Assistant Professor in the Department of Sociology and Anthropology and serves as Assistant Chairman in the Recreation Leadership Curriculum at the University of North Carolina. He received his A.B. degree from U.N.C., his M.S. from the University of Illinois and his Ph.D. from New York University. Dr. Sessoms has been a member of the University faculty since 1954, and has served as a committee chairman in the North Carolina Recreation Society. One-time chairman of the Chapel Hill Recreation Commission, he has written several articles for publication in the North Carolina Recreation Review **and other periodicals.**

forms of recreation involve considerable expense; others can be enjoyed at no cost to the individual. Polo is a wealthy man's game; walking for pleasure knows no income boundaries. Some forms of recreation require more time and energy than others. The minimal amount of time and energy neeeded for boating is considerably greater than that required for card playing.

When a person has several recreation interests, each developed to the point where he enjoys them, he is not likely to be concerned with how to spend his leisure. There is something he can do regardless of the amount of time he has. When he has only one or two leisure interests, and they are not fully developed or require more time or money than he possesses, free time may become a problem. Instead of developing interests which will allow him to wholesomely use his leisure, he seeks out an activity which requires little of him yet is a time-filler. Through it he escapes. It becomes the alpha and omega of his leisure—his short-time pursuit, his day outing, his creator of dreams, his repressor of tensions, his conferrer of medals, his constant companion. Excessive drinking is such activity. When a person knows little else to do, the chance of his using drink as recreation increases considerably. According to a study of 217 North Carolina problem drinkers, less than one-fourth pursued any form of recreation which required active (self-involved) participation. Their "interests were of the passive, non-creative, spectator type . . . creative avocations and serious cultural interests were rare almost to the point of absence."* Recreation illiteracy may be a factor in the development of some chronic drinking patterns.

The need for well-developed leisure interests is evident. If the problem drinker has few recreation skills and pursuits when he comes to a rehabilitation center, recreation education should be a vital part of his rehabilitation program. If he has several skills but is not fully utilizing them, opportunities should be made available while receiving treatment for

(Continued on page 30)

AND WHAT IT MEANS TO YOU

Stress is a basic part of our everyday experiences. How we react to it holds the key to better health and longer life.

NOBODY can escape stress. But there are varying degrees and different forms of stress—mental, emotional, physical—all having some impact—sometimes good, sometimes harmful—upon health. Stress can often be the spice of life or, depending upon circumstances and a person's capacities and reactions, it may have damaging side effects which may lead to disease, cause us to age prematurely, or sometimes even shorten life. That's why we should give thought to this thing called stress!

One outstanding authority on stress and its effects upon the human body has advanced the theory that all disease stems from it. Not all medical scientists agree with this theory, but they do recognize the link between stress—whether physical, emotional, or a combination of both—and disease.

All normal living causes wear and tear on the body. Stress has been defined as the rate of all wear and tear caused by life. All emotions—love or hate, for example—involve stress. And so does physical exertion, like a game of badminton or golf or just a brisk walk around the block. Some stress is good for us. The thing that's important is not the stress itself but it effects. Stress is a basic part of our experiences, involving our ability to adjust to changes in our lives. Whether or not the strain caused by our experiences can make our bodies break down and become susceptible to certain diseases depends to a great extent on our adaptability to these experiences. Here, then, we may hold a key to better health and longer life.

Can we teach our systems how to "take" stress? Can stress work for, not against us? Can we avoid excessive physical or mental strain? Authorities believe that by understanding our reactions, we can learn how to fight disease by strengthening the body's own defenses against stress.

Any "attack" on the body can cause stress. The "attack" might be invasion by disease germs or it might be an injury, or even an emotional crisis. Let's say that the trouble is a burned finger. The sudden injury sets off an "alarm reaction" within the body. First the nervous system sends out an SOS. Among the physical forces alerted are the body's "chemical messengers"—the harmones—which are quickly sent into action. With the aid of these chemicals, the body gets ready to handle the emergency. The tiny pituitary gland, located under the brain, dispatches a special hormone—a substance called ACTH. This pituitary hormone signals the adrenal glands, situated just above the kidneys. These glands, in turn, send out other hormones which do their share in helping to heal the burn. The pituitary and adrenal glands balance the body's chemistry so that disease can be resisted or an injury healed without overly disturbing the working order of the rest of the system.

Strong emotions, too, cause bodily changes because emotions, in general, are meant to make us act. Fear, for example, makes us tense. When this happens, h o r m o n e s speed through the system causing the heart

Courtesy of Metropolitan Life Insurance Company

to beat rapidly. Muscles of the stomach and intestines contract, forcing the blood into quick circulation. Breathing speeds up, and other changes occur which help to pitch us to a point where we can meet an emergency or go through a difficult situation. Normal emotional stress is useful in many ways. You may get "steamed up" over an important or interesting job, and, as a result, be able to handle the work more effectively. Pleasurable emotions involving stress and tension can be exhilarating. You may get excited and tense while watching a football game. This type of tension can pep you up. The letdown that follows is healthy relaxation. So it's important to know that emotional tension we're aware of is usually good, not bad for us. We can't and wouldn't want to live like vegetables—without feeling.

The emotional stress that gets us down is the kind that makes it difficult or nearly impossible to relax. Intense and persistent anger, fear, frustration or worry, which we may bottle up inside ourselves, can threaten health. It is this undue emotional stress which leads to trouble. Emotions themselves are good—indeed, valuable—for us.

Studies show that almost half the people who seek medical attention are suffering from ailments brought about or made worse by prolonged emotional stress—too much worry, anxiety, or fear. When tension of this type is too often repeated or continues for a long time—when we overwork or worry to the point where we can't seem to take it easy, no longer get a good night's sleep—our body's chemistry may get out of kilter. That's why it's important to learn to tune down if we get too keyed up, handle our emotional tensions, know and accept our physicial and emotional limitations. All this is easier said than done! But understanding is the first step—understanding ourselves and those around us, and using this understanding to make our lives and our relationships with people more satisfying.

Men Under More Stress

Men, especially, seem to have ailments which can often be traced to prolonged tension. Statistics show that women are outliving men. Survival to age 65 is more likely for women at age 20 than for men who have passed their 55th birthday! More than half the women 65 years or older are widows. Why is this? Are men weaker than women? Or can it be that men usually have to cope with more stress in their daily lives than women do? Many doctors think so. Men often drive themselves beyond their endurance because so much seems to be expected of them. Many try to live up to a picture of masculinity which portrays them as supermen—supposed to be able to "take" it—living, working, and playing at breakneck pace without a sign of weakness. But quite aside from any attempt to match a false standard of manliness, a man usually does have the very real and strenuous responsibility of supporting a wife and children. Most men want to provide not only the best for their families now, but security for the future. Being the breadwinner (and today many women are breadwinners, too) is a hard job no matter which way you look at it. Some tension is inevitable. To protect his health, a man should learn to deal with this tension as sensibly as possible. And his wife can often help.

Nobody underestimates the job of being a housewife and mother. But in spite of the many responsibilities involved, a woman's work at home does not entail the same type of strain which most men undergo from day to day. First of all, a homemaker

is more or less her own "boss." She can, if she has to, relax and let some things go. She can often find time for interesting hobbies right at home. She can vary her activities. She can usually take time to rest during the day. Not so with her husband. The family's very livelihood and security usually hinge on the way he handles his job. He is often faced with competition for a job or for advances in his position. Just the realization of so much responsibility is enough to make many men feel tense and anxious at times. What can a wife do to help? Just making the effort to be understanding is a big help. More than this, there are often little, but important things, a wife can do. A peaceful, pleasant dinner hour, for example, can be a soothing tonic, not only for her husband but for the whole family. She also helps when she saves complaints about household troubles for a time when her husband feels rested. Sometimes a wife helps her husband a lot just by listening when he feels like talking about problems he has to face on the job. Being able to "blow off steam" in this way often relieves tense feelings.

Women Breadwinners

Today, of course, many women go to work part or full time and share financial responsibility with their husbands. Although this sort of arrangement may create its own set of problems, especially if there are young children in the family, some couples do find that it makes for a good partnership which often helps to relieve pressure and worry.

Here are some of the ways people have learned to handle tensions successfully and to weather the rough spots of life more smoothly.

Balance work with play . . . That old saying about all work and no play making Jack a dull boy still makes sense. Besides, all work may also give Jack an ulcer or harm his health in other ways. If Jack—or Jill—has trouble taking it easy long enough to get some fun out of life, he probably ought to schedule time for recreation. For many people, an interesting hobby can be relaxing as well as constructive. On the other hand, work can occasionally be a kind of "cure" for emotional situations that are hard to bear—like the death of a loved one, a divorce, or the breaking of an engagement. "Getting busy" helps some people to stop stewing about their troubles.

Other Ways

Loaf a little . . . Very active people who feel guilty about occasionally just sitting and doing plain nothing ought to give themselves a chance to learn the art of loafing. While too much inactivity breeds boredom and may even *cause* stress, a few minutes a day of doing nothing may help us to tackle our work with renewed enthusiasm.

Put off until tomorrow . . . Some people need to learn to let some things go. When a work load seems overwhelming, remember you can do only one task at a time. Concentrate on the particular job at hand and then go on to the next one without worrying about everything that has to be done. Some things can almost always be set aside until later, or until tomorrow. And work usually goes faster and smoother when you have this attitude of doing one thing at a time.

Work off tensions . . . When we're upset or angry, we can try to blow off steam or work off our feelings with physical exercise. Pitching into some activity, like working in the garden, taking a long walk, playing a game of tennis or going in for some other sport, not only helps to relieve anger but makes it easier to face and

handle irritating problems.

Talk out troubles . . . It helps to "get it off your chest" sometimes by confiding worries to a sympathetic friend. When what appears to be a serious problem starts to get you down, it's wise to discuss it with your clergyman or family doctor, or with an understanding member of your own family. Often another person can help you to get your feelings into focus and to see your problems in a new light. If your problems seem to be getting out of hand, your own doctor may want to recommend a specialist, or refer you to a guidance clinic or a family service agency.

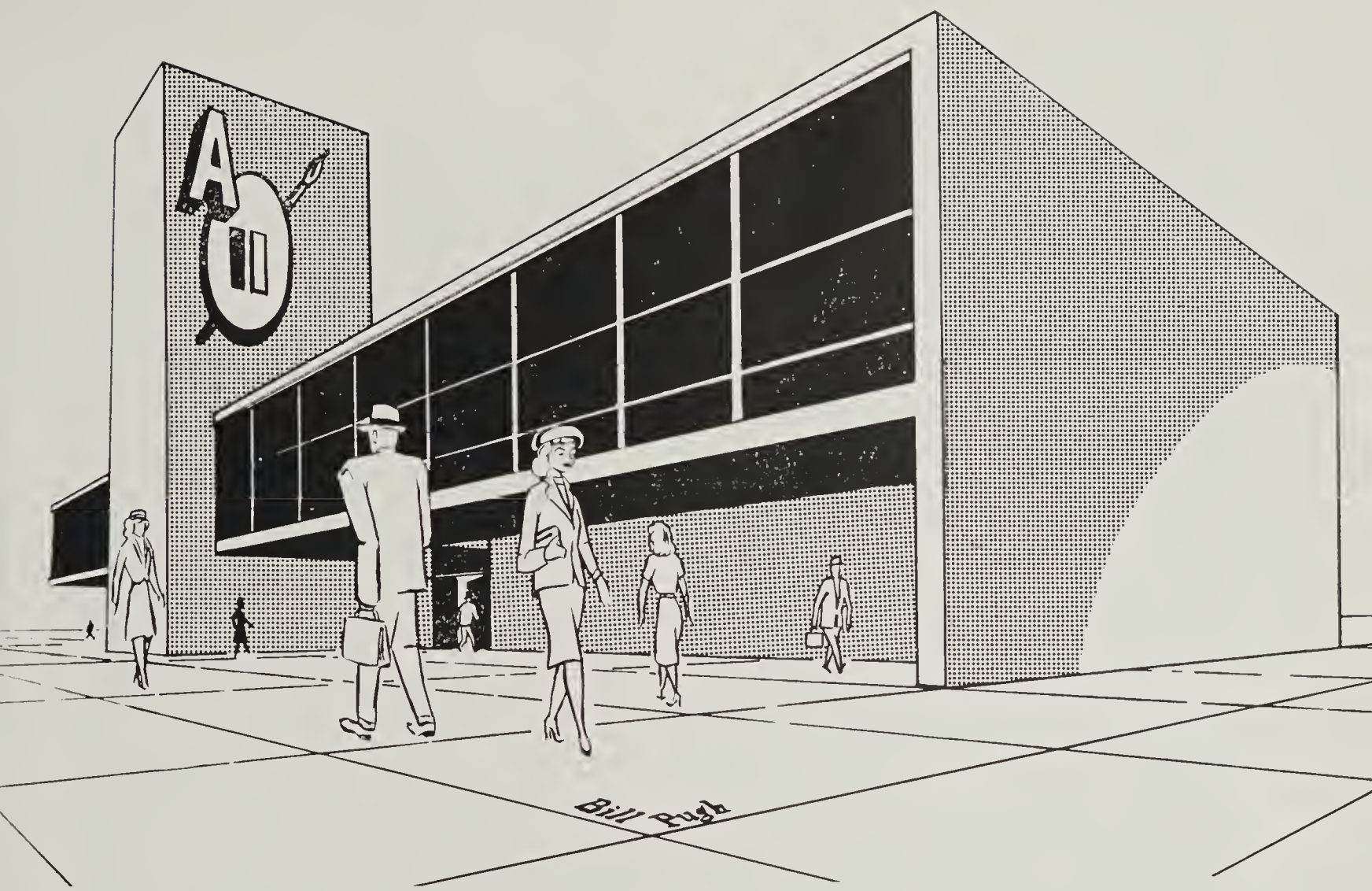
Learn to accept . . . what you cannot change. Many of us get upset about circumstances which are beyond our control. Sometimes we even try to "make people over" to suit our own ideals and then feel frustrated or let down when we find that this cannot be done. We can look for the best in others while realizing that nobody is faultless.

Get away from it all . . . When you feel that you are going around in circles with a problem or worry, try to divert yourself. As simple a thing as going to the movies, reading a story, or visiting a friend can help to get you out of a rut. And there's no harm in "running away" from a painful situation long enough to catch your breath and regain the composure you need to come back and face the problem. When possible and practical, a brief trip, a change of scene, can give you new perspective. There are times when we all need to "escape"—even if it's just a respite from routine.

Have regular check-ups . . . It's important to go to your doctor or clinic for periodic check-ups. Just as the mind affects the body's working order, physical condition affects a person's outlook on life. If you keep yourself physically fit, you'll have more zest for living and be able to take stress and handle tensions more easily.

But there are no easy ways nor simple solutions to the problems of life which cause undue stress and tension. Some of the ideas you read can be useful. Experience, too, is a teacher. And other people can be helpful. By making the effort, we often find new and better ways to deal with our tensions.

The Sixth Annual Nurses' Institute on Alcoholism will be held at the Charlotte-Mecklenburg County Health Department in Charlotte on November 18, 1960. Agencies sponsoring the Institute include the N. C. State Nurses' Association, the State Board of Health, the N. C. League for Nursing, the Charlotte Council on Alcoholism and the N. C. Alcoholic Rehabilitation Program.



Rehabilitating The Alcoholic Worker

Industry can salvage valuable employees by helping alcoholic workers.

A Texas oil refinery worker came to work with a hangover one morning and turned the wrong valve. The oil wasted cost the company about $50,000.

The highly competent supervisor of a large utility company's motor fleet began disappearing on drinking binges. Cost to the company of resulting foul-ups: an estimated $4,000 per binge.

A large Midwestern manufacturer was pleased at the pickup in business after hiring a new chief executive. Before long, however, business slacked off. Investigation showed that the new executive had taken to heavy drinking, impairing his judgment and damaging the company's standing with customers.

These men were alcoholics, whose excessive use of alcohol to meet the ordinary demands of living caused them serious problems on the job as well as at home. Their cases illustrate why there is growing concern over alcoholism in industry. Alcoholism's direct cost to industry is estimated to be in excess of one billion dollars annually.

Nearly all companies used to treat excessive drinking among workers as a moral problem that was better left alone. If an employee's drinking got out of hand, he was usually fired, not helped. But as companies have

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become aware of the high cost of alcoholism in their plants and offices, many have started tackling the rehabilitation problem head-on.

Some have set up their own programs for detecting and rehabilitating alcoholic employees. They include Eastman Kodak, Western Electric, Allis-Chalmers, Du Pont, Chicago's Commonwealth Edison and New York's Consolidated Edison. Other concerns are working closely with such community groups as Chicago's Portal House and the Houston Committee on Alcoholism.

Industry's problem centers on an estimated two million alcoholic workers out of a total U. S. alcoholic population of five million—up one million in the past five years, according to the National Council on Alcoholism. Absenteeism of these workers because of alcoholism in 1959 cost employers more than double the time lost through strikes in 1957.

Costly Disease

Alcoholism's impact on an individual company and its workers often is much greater than management may suspect. In 1956, for example, the Norton Company, a Worcester, Mass. abrasives and grinding machine manufacturer, made a survey of 33 employees with known drinking problems. They were skilled workers with an average of 16 years' service each. Eleven of the men were in an acute stage of alcoholism and on the verge of being discharged. They averaged 45 days of lost time per year, at an annual cost to each man of more than $700. The findings spurred Norton to help the workers in cooperation with Alcoholics Annonymous.

The corporate cost of excessive drinking includes such things as increased accidents, the expense of replacing trained workers and the reduced output and higher work spoilage from a disturbed drinker. "Our biggest problem is the so-called half-man—the alcoholic worker whose effectiveness is off 50 percent or more from normal," says one company personnel chief. "His mistake may not be spectacular, but he doesn't get much done."

Companies are sometimes shocked to learn that as many as three percent of their workers are alcoholics. That's because many management men still stereotype an alcoholic as a skid-row bum. These workers may present a fairly normal appearance.

"Hidden" Drinkers

Discovery of "hidden" drinkers is a major part of most company programs. Seldom will workers tip off the company about a colleague's excessive drinking. And usually the inroads of alcoholism on a worker's efficiency are made at such a slow pace that supervisors may miss the signs. (Researchers say that most alcoholic workers have a history of 10 to 15 years of increasingly heavy drinking before their illness interferes with their vocational life.) Supervisors at Consolidated Edison are trained to watch for clues; consistent tardiness or absenteeism on Mondays and frequent early departures on Fridays; unexplained disappearance from the job; recurrent accidents; unexplained changes in an employee's work habits or personality.

Unions, too, have stepped up their efforts to help detect and rehabilitate workers with drinking problems. In Birmingham, Alabama seven companies and 17 unions have joined their efforts to help alcoholic workers.

Companies with alcoholism programs generally are enthusiastic about the results. Du Pont claims its program has been "successful beyond our expectations." Some companies report the rehabilitated alcoholic

often out-produces his fellow workers, perhaps out of a sense of gratitude for being helped.

"We feel that we have salvaged some valuable employees by treating alcoholism as a disease, and, as with any illness, paying wages during treatment," asserts Volney B. Leister, personnel director of Chicago's Commonwelath Edison. His company uncovers about 15 alcoholics a year, refers them to its medical department, where treatment is determined on an individual basis.

Allis-Chalmers a few years ago estimated that its alcoholism program, now 11 years old, was saving the company some $80,000 yearly just in reduced absenteeism. Among workers treated there, the absentee rate has been cut from 8 to 3 per cent and the firing rate has been slashed from 95 to 8 per cent. An Allis-Chalmers worker with a drinking problem may be referred to the company's full-time alcoholism counselor (an AA member) by a friend, his foreman, a court or the plant hospital. During the rehabilitation program the employee is helped by members of the company's industrial relations department, which includes a psychologist, a psychiatrist, an attorney, welfare workers and a "problem counselor."

In 1952 New York's Consolidated Edison spent $25,000 to help set up a consultation clinic for alcoholism at New York University's Bellevue Medical Center—the first clinic devoted solely to the alcoholic in industry. Impressed by its value, 18 other concerns have referred alcoholic workers to this clinic.

About 85 per cent of the problem drinkers discovered by Consolidated Edison supervisors are willing to go to the clinic. Others join AA or place themselves under care of their own physicians. Visits to the clinic cost the patient $2 each, and active treatment usually runs from six months to a year. Treatment consists mainly of individual psychiatric therapy, group psychotherapy in which about 12 patients may discuss their problems, treatments with such drugs as disulfiram (Antabuse), referral to AA in some instances, and hospitalization for acute cases.

As Andrew B. Holmstrom, Vice-President at Norton says, "Our rehabilitation programs have decreased lost time at work, improved morale, and, most important of all, we know we have helped out many a home."

A well-dressed man walked into a psychiatrist's office one day and told him that he was greatly troubled.

"Just lie down on the couch and tell me all about it," the psychiatrist said.

"Well," the patient said, "the situation is this: I have a lovely family and a beautiful home, three cars, a yacht, a plane, and a string of servants. I have two country houses and a . . .

"Wait," the doctor interrupted: "This does not sound as though you had any troubles!"

"But the problem is," the patient answered, "that I only make $100 a week!"

—from the American Journal of Psychotherapy

The means of attaining designated goals which most alcoholism programs have in common are often complex and the ways circuitous.

GOALS OF ALCOHOLISM PROGRAMS

By E. M. JELLINEK, Sc.D.

From an address by Dr. Jellinek to the Seventh Annual Membership and Board Meeting of the Alcoholism Foundation of Alberta, May 18, 1960. Reprinted by permission from PROGRESS, published by the Alcoholism Foundation of Alberta.

SYSTEMATIC approaches to the problem of alcoholism had their beginnings some one hundred and fifty years ago, but the thinking of governments and the public at large about this matter was characterized by over-simplifications, clumsiness, and the idea that "nothing can be done about a drunk." The latter contention has been shown to be invalid through the activities of the fellowship of Alcoholics Anonymous and by public and voluntary alcoholism clinics. The over-simplifications have been successfully attacked by the work of a Yale University group of scientists who organized an elaborate, multi-disciplined approach to the problems of alcohol.

The activities of Alcoholics Anonymous and of the Yale Group with its researches and pilot clinic have had wide repercussions. As a result, alcoholism programs of voluntary agencies, such as the National Council on Alcoholism, state alcoholism programs in the United States, and provincial government programs in Canada, have been established.

In Canada, seven provincial governments are operating such programs, either as crown corporations or as government subsidized voluntary agencies. Five of these programs are in full operation and two are beginning activities. In the United States, forty state government programs have been established, a few of which are only "on the books." There are also some local government programs (county and municipal) and more than fifty voluntary organizations affiliated with the National Council on Alcoholism. There must be mention also of denominational programs, which have undergone revision under the impact of the scientific activities of the past fifteen or twenty years and through contact with Alcoholics Anonymous.

Most of these programs, whether

governmental, semi-governmental, or private, designate in their briefs that their goals are treatment, education, research, and prevention. These seem to be simple, straight-forward statements of goals, but when it comes to reaching these goals it turns out that the means are complex and the ways circuitous. Unexpected problems arise and there are hundreds of side issues, some of which are large and difficult.

The logical procedure would seem to be to discuss these goals one by one. They are, however, so overlapping that I doubt if they can be discussed isolated from each other.

At the Eleventh Annual Meeting of the North American Association of Alcoholism Programs, which is to be held this year in Banff, members have suggested questions for discussion. One of the questions is how does one integrate clinical, educational and research activities? I venture to submit that this is a poor question. The question should be not how to integrate these activities, but rather how to avoid their arbitrary separation, and I cannot refrain from saying that such arbitrary separation has often been the case. After eleven years of the existence of the N.A.A.P., fifteen years of activity of some of the member agencies, many avenues of approach are still not clearly seen. This lack of clarity must not be attributed to faults in administrative leadership, but to the magnitude and complex structures of the problems with which the leaders are faced.

The creation of treatment centers in a province or state is only the first approximation to the goal of prevention. Of course, there have to be first, pilot undertakings in which treatment is tested, but the ultimate goal must be to provide treatment for all alcoholics in a province or state.

Let us assume that government or private donors, or both, would supply the funds for fifteen treatment clinics in a given province. Would the cash solve the problem? What difficulties would arise and what new goals would emerge from these difficulties?

First of all, it would not be possible to staff those clinics on account of the extreme shortage of specially trained personnel. The recognition of this fact leads to one branch in the field of education, namely, professional training to supply staff for future clinics. But, even

the fifteen clinics would not suffice; and, as one cannot multiply clinics in infinity, one would also have to see to it that every general hospital should be willing and able to provide treatment for alcoholics. Such a goal involves consultation services and the extension of professional training to hospitals outside of agencies entrusted with the alcoholism program. Let us assume that we develop this large external and internal staff. Does that assure us that we shall bring treatment to all alcoholics? We may have the physical facilities and trained staff and then find that the alcoholic patients are not coming in sufficient numbers.

Why don't all alcoholics come to treatment? Why not even one-tenth of them? One might surmise that, in spite of very great efforts, the idea of alcoholism as a disease and its treatability is not sufficiently propagandized. We need education of the public on a very large scale in order to make them utilize the expanding facilities. This is not just a matter of talking louder and more frequently and distributing more pamphlets. We are up against problems of language, problems of communication. I do not think that we know how to communicate really effectively about alcoholism except to small segments of the alcoholic population and their relatives.

Communication Difficult

We use the language of Alcoholics Anonymous and we use what we believe to be a popular version of the language of clinicians and research men. But do the words we use mean to the public at large, and particularly to the alcoholic population and their family, what they mean to us? I have great doubts about it. As a matter of fact, communication on alcoholism is difficult enough between clinicians and A.A., and even within the guild of clinicians or within the guild of research men. Evidence of this difficulty is the multiplicity of definitions of alcoholism and of such terms as tolerance, sensitivity, craving, compulsion, and so on. There is even possible misunderstanding about such apparently simple terms as treatment and program. The word program means one thing to members of A.A. and quite a different thing to administrators of provincial and state alcoholism programs. Thus there may arise in A.A. a feeling that governmental and private agencies are either usurping the A.A. program or are developing something which conflicts with it.

Research Needed

In order to propagandize the idea of the treatability of alcoholism and in order to get large masses of alcoholics to accept treatment, we must find more effective words; or rather, certain sets of words for each section of the population. That is, we need research on the subject of communication about alcoholism. This matter about communication becomes of the greatest importance when we wish to engage the interest and co-operation of all community facilities in a concerted effort toward the rehabilitation of alcoholics on a large scale. You see, we cannot talk about treatment goals without considering educational and research activities.

I have brought this up as an example and I cannot go on enumerating all the complications in reaching the goals, but there are three points which I should like to touch upon briefly. The first is the goal of prevention of alcoholism; the goal to which the least progress has been made.

It has been said frequently that the treatment and rehabilitation of alcoholics involve an element of preven-

tion. This is true, but it is a limited contribution. The various alcoholism clinics, which at present are, of course, not numerous enough and work with small budgets, and the wide-spread facilities of Alcoholics Anonymous, have achieved to date no more than a reduction in the rate of increase of alcoholism.

What is required is a well devised systematic program of prevention which would cut down the need for endless expansion of treatment facilities. This matter has been left entirely to preventive education. But this is far too narrowly conceived. It does not suffice merely to describe the process of alcoholism and to teach that it is an extremely widespread, but treatable disease. No doubt such propaganda is very necessary and has its influence, but it is far from adequate.

Preventive Action

Preventive action must emanate from a knowledge of drinking customs and attitudes toward drinking. Such knowledge, of course, must be produced by research which has at present only scratched the surface. In the case of treatment, there exists a respectable, if not sufficient, fund of knowledge which can be applied, but in the matter of prevention, such knowledge is largely lacking. When such knowledge becomes available, research will then have to find the most effective way of communication.

I should like to add that there is a tendency among the activists in this field to ignore the question of legal controls of the consumption of alcoholic beverages. While it is true that many legal controls are ill-conceived, not enforceable, and have little effect, there is evidence that some can contribute toward the reduction of excessive consumption. The recent loosening of such controls in Sweden has resulted in a considerable increase of alcoholism in that country. While the devising of legal control measures is not within the province of alcoholism programs, they can, nevertheless, have an advisory role without being drawn into propaganda.

The next point I should like to make concerns a secondary, but important and cogent, objective; the assessment of the impact made by alcoholism programs. In the follow-up studies of patients of alcoholism clinics, a start has been made, and revealed considerable technical difficulties. Other measures of the impact have been rather unsatisfactory ones, such as the number of pieces of literature distributed, the number of newspaper releases, talks, radio and TV programs. In order to measure impact made by the various agencies in this field, it is necessary to find out what people know about the activities, the objects, and the methods of the agencies in their communities, province or state. The question should be, who knows what about this or that agency? What does the corner grocer know and what are his attitudes towards those activities? What do taxi-drivers know, school teachers, journalists, physicians, the so called average man etc.? All this can be found out through well devised research techniques only. Such investigations will, by the way, also contribute something towards our understanding of better communication.

Opinions Considered

Lastly, I should like to call attention to the fact that alcoholism programs develop their activities within a very definite environment and a definite climate. That climate of opinion is generated by the existence in that environment of temperance societies, welfare agencies, various

social programs, health programs, vested interests, Alcoholics Anonymous, etc., and sections of the general population whose attitude towards the problem of alcohol may be indifference, ignorance, and, in a small section, some degree of acceptable understanding. This latter section has been growing in the past fifteen years, quite considerably, but it is still rather small. While according to surveys a large proportion of the general public is inclined to accept the idea that alcoholism is a disease, their ideas about this are nebulous. They may answer the question whether alcoholism is a disease as "true," but deep down they may still feel that this is not *really* true!

The activities of the alcoholism programs may generate considerable anxiety and therefore a certain kind of opposition in various interest groups and segments of the population. We must learn, therefore, to demonstrate that the anxieties are unfounded.

What I have said here should not be regarded as discouragement. The difficulties and obstacles are by no means insurmountable, but in order to surmount them, one first has to be aware of their existence.

Supervising Attendants

(Continued from page 8)

While the duties and responsibilities of the attendant are several and varied, there is one role which stands out above the rest: that of being the patient's friend. While he is here, we want him to know that he can call on us whenever he needs a card partner, some sort of medication, or perhaps just a listening ear. And when he leaves the Center, we want him to know there will always be a warm welcome for him whenever he returns.

Clinical Psychologist

(Continued from page 10)

The second week of the twenty-eight day treatment program, which is composed of a series of five sessions currently conducted by the clinical psychologist, consists of an introduction to some basic personality conflicts and the relationship which these conflicts may have to alcoholism. The "releasing" effect of alcohol, its role in allowing one to speak and act in an uninhibited way, and the overall psychodynamic approach to the problem, are the major areas of emphasis during this period. While the group therapy program, with its introductory therapeutic films followed by group discussion, is the backbone of our treatment program, at the same time each of the full-time staff members has under his or her care a certain number of individual patients.

Research

Recently we have been meeting with our patients in small groups, with the hope that these more intimate settings will provide an atmosphere for further self-exploration and mutual interchange of ideas and feelings. Each patient is also seen on an individual basis as needed, although the emphasis is currently being placed upon therapy in groups.

As of now, it has been difficult to devote much time to research as to the effectiveness of the treatment process here at Butner. However, we are increasingly aware that continuing self-improvement depends upon continuing self-evaluation, and have undertaken to assess the attitudes of both patients and therapists toward several of the actual and ideal characteristics of helpful group therapy sessions. A group therapy rating scale has been devised wherein the relative importance of partici-

pation by the patients and the leader may be evaluated. In addition, we are concerned with the choice and the timing of various kinds of participation of both leader and patients. Through these preliminary, groping attempts toward improving the group therapy process at our treatment center, we hope to expand our research program to include manifold dimensions of group interrelations.

Occupational Therapist

(Continued from page 13)

tions, motion pictures describing various activities, exhibits, and through group and individual therapy. In this way, he can demonstrate the real values of recreation. Once the interest of the patient is aroused, the recreator teaches the necessary skills, if possible, or at least provides a stimulus for learning, such as some information on the subject.

Oftentimes, staff members will prescribe as a means of therapy specific recreation activities for particular patients. It is the responsibility of the recreation therapist to see that these "prescriptions" are filled.

Because of the smallness of the Butner community, no commercial recreation is readily available for the patients. Thus, the staff recreator is actually responsible for providing *all* of the recreation activitives for the Butner patients during their four-week stay. Such activities as summertime cook-outs, fishing trips, swimming parties and square dances are enjoyed by the patients.

In planning recreation activities at Butner, special consideration must be given to the therapeutic value of group participation and a well-balanced recreation program in order for this part of the treatment program to be effective and beneficial.

Medical Director

(Continued from page 9)

time-wasting duplication of effort. A continuing process of self-evaluation is inherent in the present operational philosophy.

Our behind-the scenes look at the Center would be incomplete were we to fail to take note of the various research activities currently under way both by staff members and visiting experts of various disciplines. Without critical appraisal of our treatment methods, no improvement in these would ever be possible. Within the field of alcoholism are encountered all the major problems which have been of interest to investigators within the mental health professions for many years. The possible effects of early childhood experiences on adult behavior, the efficacy of various forms of psychotherapy, and the development of improved treatment techniques are only a few of the many complex problems which engage our attention. Any contributions which the Alcoholic Rehabilitation Center staff may make in attempting to elucidate them will be of benefit not only to alcoholic patients but to sufferers from many different forms of emotional illness.

Vocational Director

(Continued from page 12)

Carolina Employment Security Commission and other agencies in the community which are concerned with finding positions for the unemployed.

In addition to these responsibilities, the counselor participates with other staff members in group therapy discussions. However, the major function of the vocational guidance director is that of helping the patient to help himself.

Psychiatric Social Worker

(Continued from page 11)

sessions in which he and I will take part, and as a result of his contacts with other patients and staff members.

In light of the knowledge I have gained of my patient, I will help him to find a way of continuing the help he received at Butner in the community after he leaves us. He might have a family problem which needs the skills of the Family Service Association. If he will accept it, he will find a tremendous source of strength and support from the fellowship of Alcoholics Anonymous. Perhaps he can do best for himself through the services of the local Mental Health Clinic, or through special counseling with his pastor. Very often, through arranging to see the patient's wife (with his consent), help can also be given to her, so that they may learn how to work together on this problem which involves the entire family. Whatever the problem, I shall try to help the patient handle it according to his abilities and limitations, remembering that his needs are the yardstick, and not my own, and that he can be compared with no one but himself.

Social workers are human, too, and so it is always gratifying to learn that one's patients have done well—regained their earning power, renewed family ties, stayed sober since leaving the Center. But, being human, we are also aware of human fallibility, and so I do not become discouraged if a patient returns to the Center for further treatment, having had a "slip." Rather, I feel complimented that a patient in such a predicament feels confident of a welcome and a willingness to help him make another try. This is my job—to accept, to understand, to help within the limits of my own competence and abilities, and never to forget that the most important person at the Center is my patient, whoever he may be.

Recreation and the Excessive Drinker

(Continued from page 15)

him to rekindle and sustain these interests.

Professionally trained recreators should be a part of the medical rehabilitation staff. Adequate recreation facilities must be provided. Opportunities for positive leisure expressions of all types—music, sports, passive activities, short-term activities, highly involved pursuits—must be included. There should be something for everyone regardless of his income, age or cultural background. Guidance should be offered but freedom of choice must be maintained.

Proper attitudes must also be developed. Recreation and idleness are not synonymous. Recreation contributes to personal well-being; it is a wholesome use of time. There should be no feeling of guilt because one is doing something for pleasure. The by-products of recreation (good health, balanced growth, good citizenship etc.) are innumerable.

Finally, recreation can be a force in the prevention of chronic drinking. If youth are taught the art and skills of leisure, the chances of their using drinking as recreation are lessened. Free time is never a problem for the recreationally literate.

***Kelly, Norbert. Alcoholism and Social Experience, p. 64. North Carolina Alcoholic Rehabilitation Program, 1954.**

No man can stand alone—
Be he the treater or the treated.
Inherent in the healing arts
Is this thread of truth.
The dignity and worth of man
Is balm for the defeated.
It is strength for those
Who would minister to him.
No man can stand alone.

I believe the alcoholic is a sick person who is especially reactive to alcohol.

I believe the alcoholic is an individual worth helping, who can be helped.

I believe the responsibility of helping alcoholics is that of the healing profession as well as established health authorities and the general public.

I believe alcoholism is a complicated disease entity and a problem involving many other problems.

I believe I cannot make any alcoholic stop drinking. He can stop for only one reason: an honest desire to stop.

REALIZING I have limitations, I will be alert to all community resources dealing with this problem.

I will look upon the alcoholic as a person with physical, mental and social problems.

I will look upon the family of the alcoholic as one being influenced by the mental, physical and social problems of the alcoholic as well as an influential factor.

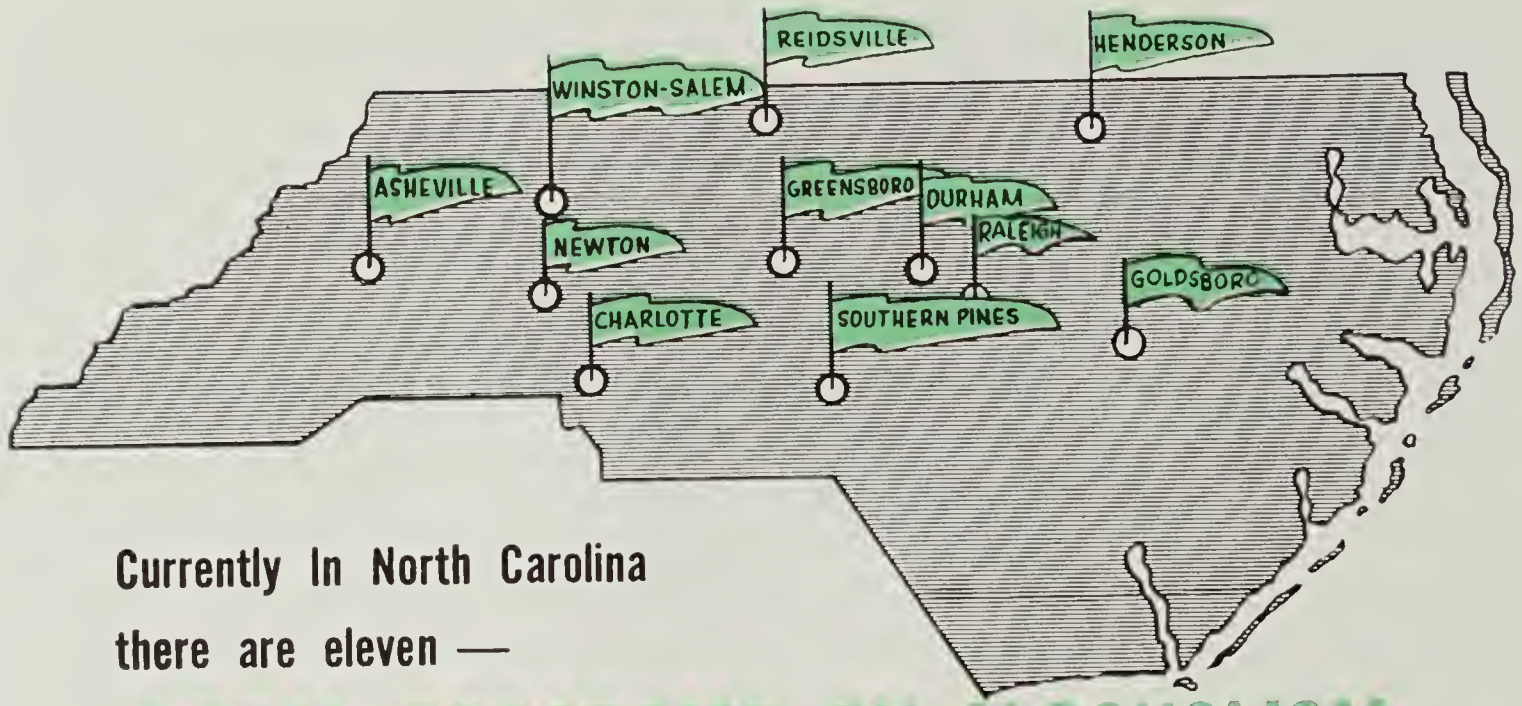
I will work with the family of the alcoholic in order to help them understand the nature of the disease and encourage them to adopt a positive attitude rather than a negative one.

I will use every means of communication to create a more understanding public regarding alcohol and alcoholism.

I will not allow any personal prejudice to interfere with my professional relationship with the patient.

I will dedicate myself to greater understanding of the problem of alcoholism.

—Composed by a group of health education graduate students in a course on alcohol education in the University of North Carolina School of Public Health.



Currently In North Carolina there are eleven —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Don Dancy, Educational Director

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—
Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program
300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 West 4th St., Winston-Salem
Marshall C. Abee, Executive Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

NOV.-DEC., 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

The Status of Alcoholism

A Patient's View of Therapy

Emotions and Physical Health

Future Needs of Alcoholism Programs

Alcoholism Information Week

Letters to the Program

What's Brewing?

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,

compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a through medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM OF THE NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

VOLUME X **INVENTORY** NUMBER 4

NOVEMBER-DECEMBER, 1960

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it. Manuscripts invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

WILSON, N. C.: A workshop sponsored by the Wilson County Mental Health Association and conducted by the NCARP on November 16 resulted in a decision to organize a community council on alcoholism. James Hunt of Lucama was named chairman of a committee to proceed with the plans. Approximately 75 people attended the workshop according to Mrs. J. C. Eagles, Jr., president of the association. Dr. Irene McFarland was its chairman.

SHREVEPORT, LOUISIANA: John Fleming, member of the Louisiana Commission on Alcoholism, has announced that the Caddo-Bossier Council on Alcoholism will conduct its Fifth Annual Institute on the Problem Drinker April 12th and 13th, 1961. Co-sponsored by Centenary College, Shreveport, Louisiana, the institute will be held at the Captain Shreve Hotel.

WINSTON-SALEM, N. C.: The Alcoholism Program of Forsyth County has a new director, Thomas A. Gilyard of Winston-Salem, who was appointed by Mayor Marshall Kurfees to succeed E. A. Hoffman on the education committee. Hoffman, who worked with the Western Electric Company, was transferred from the city. Gilyard is department chief for benefit, hospital and safety service at the Western Electric Lexington Road plant. Officers of the program said Gilyard has shown an interest in its work, referring cases to the staff and working with alcoholism problems. The education committee is responsible for community and industry educational activities.

POLAND: The Polish press recently reported that alcoholism is Poland's most frequent cause of suicide and the country of 25 million population is spending 10 million dollars daily on hard liquor. Nearly a third of 1,564 suicides in 1959 were chronic alcoholics. Liquor consumption is increasing despite higher prices.

RALEIGH, N. C.: The NCARP was reviewed "in perspective" and "in the future" at its Tenth Anniversary Dinner held at the new Raleigh YMCA December 2. Among the special guests attending were Dr. Eugene Hargrove, Commissioner of Mental Health of the N. C. Hospitals Board of Control, governing body for the NCARP, and John Ruggles of Southern Pines, chairman of the 1949 Committee which was assigned the task of recommending a program of action against alcoholism in the state. Representatives of mental health clinics, Alcoholics Anonymous, and community alcoholism programs also joined the NCARP staff and their families for the commemorative exercises.

NEW YORK CITY: More and more of the dollars spent in United States liquor stores these days come from women's handbags, the **Wall Street Journal** reports. Some members of the National Liquor Stores Association indicated that 70% to 75% of their customers are women; many noted an increase in women customers. Other trends: more people are drinking a greater variety of alcoholic beverages; straight whiskey and the lighter, lower-proof variety are growing in popularity; annual draught beer sales in the United States, now, at 15% of total, are declining; in Canada draught beer sales at about 22% of total are about the same as the last three years.

CHARLOTTE, N. C.: The Sixth Annual Nurses' Institute convened at the Charlotte-Mecklenburg County Health Department November 18. Attended by approximately 200 hospital, private duty, industrial and public health nurses from all over the state, the program featured discussions of attitudes toward alcoholism and causes of the illness by Roberta E. Lytle of Raleigh, a psychiatric social worker, and Dr. John A. Ewing of Chapel Hill, a psychiatrist, respectively. Other features included a panel discussion on "Management of the Alcoholic Patient" and the presentation of two case histories to which a panel of nurses "reacted." Representatives of community resources for alcoholism in the Charlotte area were also on hand to explain their services. The sponsors were the N. C. Nurses' Association, N. C. Board of Health, N. C. League for Nursing, Charlotte Council on Alcoholism, and the NCARP.

TORONTO, CANADA: Dr. Nevitt Sanford, professor of psychology at the University of California, Berkeley, has been named general and scientific director of the new Co-operative Commission on the Study of Alcoholism, according to H. David Archibald, executive director of the Alcoholism Research Foundation of Toronto and president of the North American Association of Alcoholism Programs. Financed by an unprecedented million-dollar grant from the National Institute of Mental Health of the United States Government, the international commission will spend five years delving into every field of study relevant to the understanding and relief of alcoholism in the United States and Canada. The California professor expects to take over direction of the comprehensive five-year study in July of 1961. In the meantime, he will be concerned with locating the project headquarters in a suitable university and recruiting key members of his staff.

Mailing List Request

We would appreciate it if you would place our names on your mailing list for any literature or monthly circulars which your Commission issues.

We feel such literature would be of use to us in connection with a new Alcoholic Bureau recently created in our Police Department.

Thomas F. Daly
Stamford, Conn.

Discovers Inventory

A copy of *Inventory* fell into my hands, and it is what I need, and can use, in our work in a Men's Center. May my name and address be placed on your mailing list so I may receive this journal as it is published?

Brigadier Milton Kippax
The Salvation Army
Altoona, Pa.

AA Team

Please put my husband on your mailing list. We attend A.A. and Al-Anon meetings togther and will take our copies there to give to others to read.

Anonymous
Harrisonburg, Va.

Informative And Helpful

I am requesting that you send me the journal, *Inventory,* and I would appreciate it if you would consider this letter notification for placing my name on your mailing list for this journal. Being in psychiatric nursing, I found the material in your January-February issue very informative and helpful.

Sister Dominic Marie
St. Vincents Hospital
Harrison, N. Y.

Assistant Director Writes

I am an assistant director here at Pioneer House, an alcoholic rehabilitation center run by the city of Minneapolis. I have had occasion to see your publication, *Inventory,* and would certainly like to be placed on your mailing list.

Edward D. Juergens
Minneapolis, Minnesota

Excellent Publication

I would appreciate it very much if you would place our Department of Nursing on your permanent mailing list for your excellent publication, *Inventory?* We wish to utilize it as resource material for both nursing students and faculty.

Helen L. Allen
Arcata, California

Literature Request

Please send us one copy each of your *Directory of Facilities for Alcoholics in North Carolina* and your booklet for the clergy, *Alcoholics Are God's Children, Too.*

Abbott J. Schulman
Lenoir County
Health Department
Kinston, N. C.

EDITORIAL

The arrival of the "New Year" marked the end of the North Carolina Alcoholic Rehabilitation Program's first decade of service and the beginning of its second. This issue of INVENTORY, coinciding with the event, contains three articles by officials of the NCARP which suggest, among others, several "resolutions" for consideration by all persons who are interested in or concerned with efforts to solve the problems surrounding the complex illness, alcoholism, in the years ahead.

Resolutions, 1961

1. Let's work together to fill the gap between the facilities we now have for helping alcoholics and their families and those we MUST add in order to meet their individual needs.

2. Let's promote more organized studies of patients who have sought our help to determine the whys of treatment successes and failures and the differences between the patient who remains sober and the one who continues drinking.

3. Let's delve into the unknown in search of new knowledge about the psychological, physiological, and sociological aspects of alcoholism.

4. Let's pause to evaluate our efforts in education, as well as treatment, and resolve to maintain a readiness to adjust to changing knowledge.

FUTURE NEEDS

THERE IS HOPE FOR THE ALCOHOLIC

About The Authors

Dr. Eugene A. Hargrove is Commissioner of Mental Health for the North Carolina Hospitals Board of Control, the governing body for the state mental hospital system and the North Carolina Alcoholic Rehabilitation Program. Dr. Donald E. Macdonald and Dr. Norbert L. Kelly are medical director and associate director, respectively, of the NCARP. The articles by Dr. Hargrove and Dr. Macdonald were originally given as talks at the NCARP's tenth anniversary celebration. Dr. Kelly prepared his as a companion article to round-out a discussion of the future needs of North Carolina's alcoholism program. The State of North Carolina has, for the past ten years, been carrying out a three-pronged program of education, treatment and research to bring an understanding of alcoholism to its citizens and to offer hope for recovery to those already suffering from this complex illness.

NCARP AND THE FUTURE

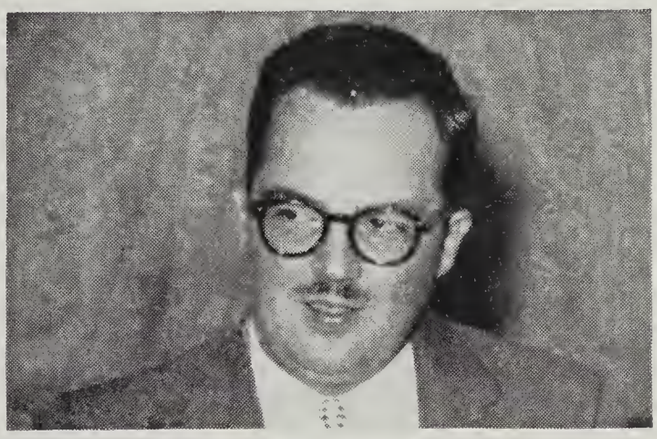
BY EUGENE A. HARGROVE, M.D.

The idea that a medical, therapeutic approach to alcoholism is possible rather than a punitive or indifferent one has only been emphasized in our country in the last twenty years. Our own program, which is a medical and educational one, is only ten years old and bears witness to the recently recognized medical attitude toward this problem. Young as our program is, it is relatively old in terms of rehabilitation programs throughout the country.

The problem of alcoholism is a difficult one. There are many alcoholics and it is often difficult to maintain a therapeutic, redemptive attitude with them. Working with the alcoholic can be frustrating, discouraging, and often unrewarding to families, physicians and other professional personnel. It is easy to understand why antagonistic punitive attitudes have developed but it is

(Continued on page 8)

OF ALCOHOLISM PROGRAMS



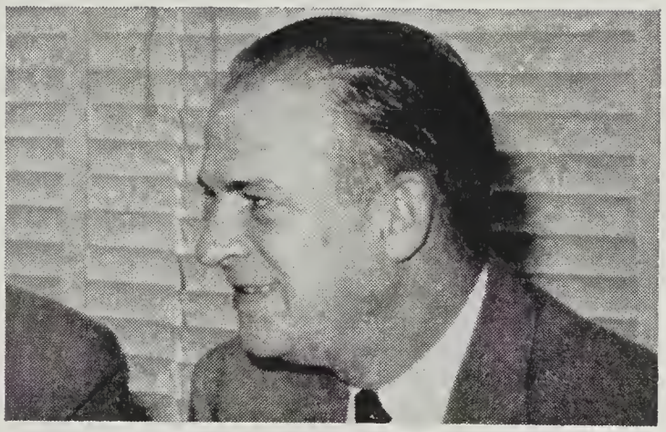
FRONTIERS OF RESEARCH

BY DONALD E. MACDONALD, M.D.

While we may take pride in the progress and accomplishments of our North Carolina Alcoholic Rehabilitation Program during this past decade, it is nevertheless necessary every so often to remind ourselves of the large number of unsolved questions surrounding this baffling illness which we call alcoholism. We talk of alcoholism treatment, alcoholism prevention—yet an adequate definition of the condition eludes us like a will-o'-the-wisp. Is the illness psychological in origin, or physical; are there elements of both present? Is it genetic, or acquired? Is alcoholism an addiction, or is it not? Is it an illness at all, or a moral problem? What is an illness, anyway?

These questions and many more must be faced by all—both layman and professional—who are concerned with this problem. We need to know in more detail the actual extent of alcoholism in our society, to

(Continued on page 9)



ARE ATTITUDES BASIC?

BY NORBERT L. KELLY, Ph.D.

At our Sixth Annual Nurses' Institute on Alcoholism held in Charlotte a few weeks ago, I was impressed by the centrality of the concept of attitudes to the illness of alcoholism. Toward the end of the institute, when I was summarizing the proceedings, I found my thoughts returning again and again to their importance.

Seemingly, on the basis of current knowledge, attitudes play a major role in etiology, in the precipitation of the illness, in treatment, and in the reintegration of the patient into family and community after treatment.

The way the family in which the alcoholic-to-be grew up accepts and values him; the manner in which the individual assesses his spouse and family threats; the acceptance or rejection of him by the treatment team; the understanding or hostility of family, employer, and church—

(Continued on page 10)

NCARP And The Future

(Continued from page 6)

very gratifying to see, more recently, the constructive change in attitude to the alcoholic, both medically and socially. Much of the difficulty we have with alcoholism is the lack of understanding of the very nature of the problem.

In addition to the difficulties which the individual himself presents, the large number of alcoholics poses a problem. It is estimated that there are approximately five million alcoholics in the United States with some six hundred thousand so severely affected as to suffer permanent physical and mental damage. Even in our own program the large number is astonishing. We are at the present time admitting approximately 1500 alcoholics a year to the 200 beds which we have available to alcoholics in our State Mental Hospital System. Thirty-seven percent of the admissions to Dorothea Dix Hospital at Raleigh are because of alcoholism. Alcoholism is the largest single diagnostic category we admit to our hospitals.

Flexible Program

Because of the complexity of the problem there is need for a wide spectrum of treatments. No one approach is effective with all alcoholics. Along with a wide variety of approaches we need a comprehensive, integrated but flexible program which will include units for acute problems of alcoholism. Especially the general hospitals should have them. More units sufficiently staffed to provide adequate psychotherapy for the chronic alcoholic and his family should be provided in state psychiatric and general hospitals. It is often through psychotherapy that the alcoholic and his family come to understand his problem and learn to act more constructively. We perhaps even need a few special facilities which are designed to care for the alcoholic only. Such units, however, are difficult to staff because of the highly specialized approach. Outpatient units at the state psychiatric hospitals, the Alcoholic Rehabilitation Center, general hospitals and special facilities (if they exist) are much needed. Although our program is ten years old, we have not had sufficient outpatient follow-up to evaluate the effectiveness of outpatient programs. As a part of outpatient facilities and treatment our mental health clinics must help in evaluation and follow-up. Easy accessibility of the alcoholic patient to a mental health clinic oftentimes can prevent his relapse.

Trained Personnel

A high priority, among the needs, is more personnel. Toward this end our medical schools and our graduate training programs for physicians should teach about alcoholism. In this connection of training, the general physician, for example, can gain a good deal of understanding through institutes and postgraduate courses on alcoholism.

I would say that there are four needs we face today in the alcoholism programs:

1. We need more and better facilities for service with active and adequate treatment and rehabilitation programs on a local and state level.
2. We need more and better trained personnel to provide these services.
3. We need a more understanding climate of public opinion. Our own educational program on alcoholism which Dr. Kelly heads so effectively is certainly helping our communities to accept their responsibilities toward this

tremendous problem.

4. We need more research to learn about the physiologic, the psychologic and the social mechanisms which produce alcoholism. Our own program is forging ahead in this area and has some definite plans.

Comparing North Carolina's alcoholism program to the growing human, we are ten years old. At this age, it is a well-known fact that a child's basic character is well set. I believe we can see the character of our own alcoholism program as it has emerged—a service-oriented, humanitarian character which attempts to provide a comprehensive, integrated but flexible program with many ramifications throughout the state.

Frontiers Of Research

(Continued from page 7)

know more about the so-called "hidden alcoholic." The epidemiologists can help us here with their experience of other illnesses. Follow-up studies must be carried out so that we can gradually assess the effectiveness or ineffectiveness of treatment programs of various kinds. How does the sober alcoholic differ from the alcoholic who continues drinking—are there psychological differences, or biochemical ones, perhaps? We do not know at this time.

Alcoholism is seen by many as a facet of the total mental health problem area within a society or community. Here again, however, we quickly encounter difficulties in definition where glib phrases pass for explanation. There are as many unsatisfactory definitions of mental health as there are of alcoholism and, at the moment, it is not particularly helpful to try to explain one in terms of the other.

Turning now to some of the possible biological bases of alcoholism, we find our knowledge and understanding no less lacking than in the psychological sphere. It may come as a surprise to some to discover, for instance, that we do not know, even today, precisely how alcohol is broken down in the human body. We should like to know much more about the action of alcohol on the central nervous system than we do; the implications for improved treatment of such conditions as delirium tremens upon research of this type are very great. Biochemists are presently engaged in elucidating possible relationships between the metabolism of alcohol and that of carbohydrates and certain protein substances. There are already tantalizing hints of biochemical abnormalities which may be common to alcoholism and other types of mental illness. If this should prove to be the case, then many other questions have to be answered. For example, are these biochemical variations genetically transmitted as certain metabolic illnesses are now known to be? We can see here how the psychiatrist, neurophysiologist, biochemist, and geneticist must combine forces to shed light on these obscure but exciting problems.

Other Questions For Research

Many other questions await definitive study. Why do people vary in their reaction to the experience of ingesting alcohol, some finding it a pleasurable sensation, others finding that it leads only to nausea and disgust? Could the potential alcoholic be spotted by his particular type of reaction? What about the phenomenon of tolerance to alcohol? Is there some characteristic difference again in the potential alcoholic which might give us some clue in the early stages of the illness? This type is of the greatest practical im-

portance, as it might conceivably lead to the selection of patients for specific treatment procedures based on their particular physiological or psychological traits.

I think it is important to emphasize that research is not a thing apart, but that it is an integral part of the day by day functioning of any treatment unit. There can be no treatment without research, and no research without treatment. Whenever we undertake the treatment of an alcoholic patient, we embark on a research endeavor. There is no such thing as "routine treatment" of the alcoholic.

Within our own treatment center at Butner, for example, we have begun to study the group psychotherapy process which forms our basic treatment technique. Also, some intriguing work has already been done in North Carolina on the possible relationship between alcoholism and other psychosomatic conditions and we hope to continue working along this line. As I have tried to indicate, it is only through this kind of investigative activity that our treatment program will come to be of maximal service to the citizens of North Carolina.

Are Attitudes Basic?

(Continued from page 7)

all apparently may be involved in the course and successful outcome of the illness. Of paramount importance may be the alcoholic's self-attitudes and his definition of his illness.

Significant, also, may be the attitude of society toward the use and overuse of beverage alcohol. The ambivalent attitude of the Greater American culture toward alcohol and, perhaps more importantly, the recreational attitude are worthy of note. These orientations are in sharp contrast to the dispositions found in certain American subcultures and certain continental cultures where alcoholism does not occur or is rare. It may be that one important factor in the etiology of alcoholism is the *meaning* alcohol has in a given society.

Bringing our attitudinal camera into another focus, what can it reveal about alcoholism education?

Obviously, all that has been written above bears some relationship to alcoholism education. At one time or another the content of educational messages will contain the concepts discussed.

Evaluation In Education

More specifically, however, one of the important educational segments we deal with is attitudinal change or crystallization. This is one of our aims when we work with teachers, employers, physicians, nurses, spouses, law enforcement officers, ministers, other social agencies, or the public in general through the mass media. One wonders how much change we are achieving.

For some ten years now, there has been an ever increasing flow of alcoholism education in the state of North Carolina. All available media are being energetically employed—institutes, workshops, speakers' bureaus, exhibits, college courses, radio spots, TV spots, radio and TV programs, film libraries, book libraries, book donations, newspaper features, professional publications, magazines, literature distribution, etc. Many a night members of our staff drive down lonely, dark highways jumping from one engagement to another, from one part of the state to another. These last six months have been the busiest in the history of the NCARP. This morning a request came in from a professional journal to review four books within two

weeks. They'll have to be read and reviewed "on the fly."

The number of community councils has multiplied. Their work is constant, ever expanding. They are performing at the grassroots level at the same fast pace.

In all this activity there is an implication that objectives are being achieved. In reality, we know as little about what we are accomplishing as those working in treatment. In education, as well as treatment, there is a definite lack of follow-up and evaluation.

Any of us, of course, can cite specific instances of achievement. There is the druggist who had his license restored after a member of the licensing board heard a speech on alcoholism. There is the teacher, following a college course, who helped a neighboring family understand the illness of one of its members and aided him in getting treatment. And the minister who was instrumental in introducing alcoholism education in his seminary after four weeks at Yale. Another case is the young housewife and mother who was grateful for having "her eyes opened" during a workshop on parent-child relationship.

One could go on and on with specific examples of accomplishment. But in comparison to the total effort being expended, what are we achieving? Hasn't the time come for real evaluation? Doesn't the alcoholism educator need to add to his arsenal of attitudes one of inquiry? Is there a need to slow down and take stock? Perhaps this should be one of the major functions of a state program as the local councils develop and take over the educational function.

Again, education, like treatment, is tied to basic research. We can only advance as research evolves knowledge. Much of today's educational content lacks precision because the flow of new knowledge is so slow. We write and talk and broadcast about the importance of symptomatology. But there is no precise symptomatology. There is much talk about education for prevention. But what actually is education and what is prevention? We need specificities.

There are dozens of questions that could be raised. They need to be raised in the field of alcoholism. Progress against the illness depends upon evaluation and research.

One aspect of maturity, we are told, is the ability to operate on tentative knowledge. In alcoholism education we must do just this. But we should realize what we are doing and be prepared to change with changing knowledge. But more than this, the educator should look inwardly, inventory his own specialty, and make the necessary changes.

In our last issue of INVENTORY, we published an article entitled "Recreation and the Excessive Drinker" by Dr. H. Douglas Sessoms. In the first paragraph of that particular article, several of our figures were incorrect and we inadvertently omitted a phrase. We would like to correct those errors. The sentence reading "Of this amount, two billion was spent for travel and 9.2 billion for alcohol" should actually read "Of this amount, two billion was spent for commercial and spectator entertainment, fifteen billion for travel, and 9.2 billion for alcohol." We apologize for this error and hope that this correction will reinstate us in the good graces of the University of North Carolina Sociology Department!

A PATIENT'S VIEW OF THERAPY

BY A FORMER FOUNDATION PATIENT

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I came through the doors of the Foundation completely bankrupt —socially, financially, and domestically. I had been talked at by many people—family, employers, social workers, nurses, doctors, ministers; but it was not until I reached the Foundation that I met anyone who seemed to be able to understand my problem. The Foundation counselors accepted me as I was, wallowing in self-pity. But they did not wallow with me. I was financially in extremely bad shape, but there was no quick hand-out. I was hostile to the whole world, and was given the opportunity to verbalize as much hostility as I cared to. My counselor listened patiently to it all with no indication as to whether I was right or wrong. This was the way I felt and the way I felt was important. I projected my feelings and my sorry plight in a hundred different directions, and each was accepted, discussed, and then I was allowed to come to my own conclusions. There was a great deal of guidance, but I was never allowed to become too aware of it.

This took time, and time is a significant factor in the recovery of an alcoholic. He cannot tolerate hurry and pushing in other people, because people have so little time for him. The first person who gives the alcoholic the time to pour out his feelings, who listens to his hostility and projection, is going to be able to build a relationship that can later be used in a therapeutic way.

Most of the alcoholics I know are

Until he sought help, this patient found one drink was too many and a hundred not enough. But therapy administered by understanding counselors plus Alcoholics Anonymous have kept him on the road to sobriety.

basically intelligent people and, what is more important, people who have a keen ability to sense the feelings and attitudes that are radiated by those they meet. The active alcoholic's whole life is one great wall of defense to protect him at all costs from the realization of what he is doing to himself. He has experienced the constant attempt of people to break through his rationalization system until he is continually on guard and extremely quick to take offense as a weapon of protection. With the least hint of criticism he retreats into his shell of defense. His energy is used in developing defenses, rather than developing himself.

The active alcoholic cannot be expected to react to logic or common sense. He is in the peculiar position of being very sick without knowing it; for he is always the last to realize he is an alcoholic. He shows none of the physical symptoms apparent in other illnesses, yet there are recognizable symptoms in every area of his life. If these symptoms (gross rationalization, chronic irrational behavior, extreme irresponsibility etc.) appeared without the uncontrolled drinking, we would immediately realize that there was something seriously wrong and we would be quick to urge the alcoholic to seek treatment.

Yet with alcoholism, there is a tendency to sit back and allow the condition to carry on year after year without realizing that unarrested alcoholism, because of its progres-

sive nature, can only end in one of two ways: death or insanity. Ironically, alcoholics themselves were the first to find the answer to their own problems, and Alcoholics Anonymous was born out of their own need. Since that birth, much has been learned; treatment techniques have been developed, theories have been put forth, and a great deal of research has, and is, and will be carried out. But no matter how much we learn, one basic factor still remains. The suffering alcoholic must be approached with knowledge, warmth, and understanding to bring him to recognize his illness, and then his need, and right, and obligation to seek treatment and stick to it.

Job Problems

By the time I applied to the Foundation for treatment, I had had and lost many jobs. Because of my irrational behavior and frequent absences, I was criticized and abused by employers, with no defense that had the slightest chance of being accepted. I was warned and threatened repeatedly, and had to approach the next prospective employer with little or no recommendation. Through necessity I had to lie and cheat in order to secure employment, and then work under the strain of being found out. I carried the anxiety and tension that were built up inside me until the pressure became so great that I had to have some type of pain-killer. The type I knew best was alcohol. I used rationalization to justify that first drink, only to rediscover that one drink was too many and a hundred not enough. So the same old routine started all over again until fear and tension became so strong that I began to question my own abilities. My self-confidence would be so threatened that when I applied for a job, it was with an apologetic, negative air until the day came when I quit trying and began to use my alibis to avoid seeking employment at all.

Alcoholics Are Human Beings

Many wonder why so many wives stick with their alcoholic husbands through untold misery. A common remark is "If I were that woman I wouldn't stay in the situation five minutes." Why do families stay? I think it is because the alcoholic is basically an average human being with all the warmth, kindness, understanding, humor, wit, and pathos that make up a worthwhile person. Because of the nature of the illness, his personality appears to be greatly changed and defenses and rationalization take the place of many normal emotions. Extensive and intensive periods of intoxication weaken emotional controls and exaggerate some personality characteristics, and so starts the typical Jekyll and Hyde behaviour of the alcoholic. Yet, throughout his alcoholism, there are still bits and pieces of his personality, the parts that once endeared him to his family still breaking through: promises of hope that some day the original father or husband, son or daughter, may come back bringing happiness to the family once again. You must remember we were not always alcoholic. Once we had all the ingredients of a good life, and memories of happiness are longer than those of unhappiness.

Feelings Toward Family

What were my feelings when I thought about my family? I wondered why I hurt them so much when hurt was not intended. I wondered why I let them down when really I meant with all my heart to keep my promises, and why I neglected them when the best is none too good for them. These are the agonies that

many alcoholics experience in the hangover period and sober periods that follow the prolonged benders. How could we forget these people we love during our uncontrolled drinking periods? We do it because we are sick and cannot accept our illness. We do it because of the confusion our illness creates, not only for ourselves, but also for the people who are close to us. We carry on in our illness because we cannot understand that treatment and resulting sobriety will remedy most of the complications that appear to be the illness, rather than the results of the illness.

Many alcoholics become completely dissocialized, as I became, and our families must share this with us. Why do we feel this dissocialization so greatly? I believe it is because it signifies the loss of the most precious ingredient of all, human dignity. Perhaps it is because the alcoholic has experienced this loss that, when he once again is restored to health, he becomes a real asset to our society through the understanding of his great need for the love and respect of his fellow man. Perhaps, too, this loss of self-respect and the respect of others is the greatest barrier to his seeking treatment for his illness, so that those who are trying to help him must, from the beginning, try to restore some spark of his human dignity. It is a terrible feeling to hate yourself utterly and completely, and be so consumed by this self-loathing that you completely cut off all other human relationships.

Many can help alcoholics seek treatment, by understanding the nature of alcoholism, by giving the alcoholic sympathy and understanding, and at the same time by dealing with him in a constructive way.

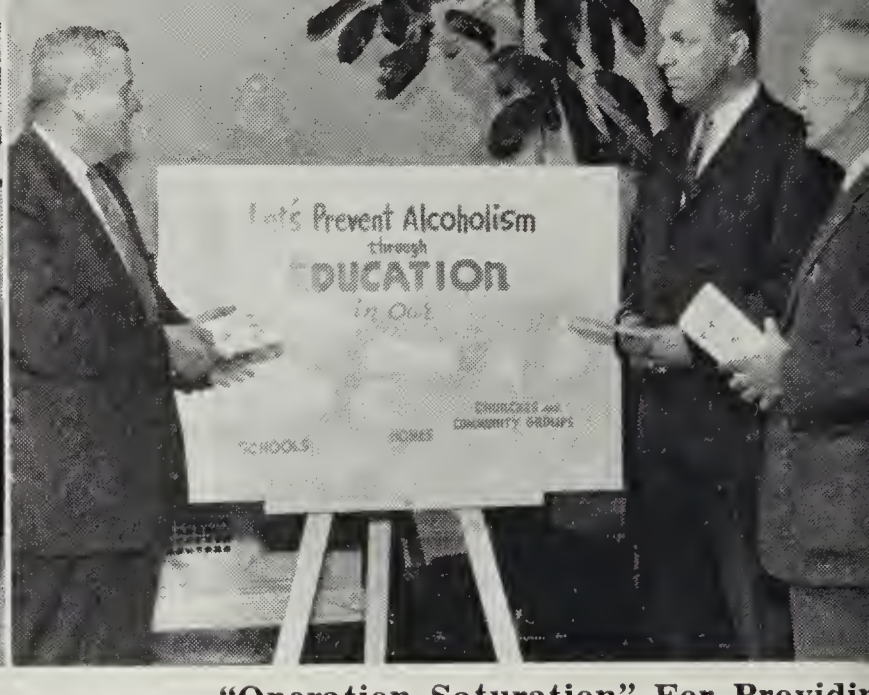
The alcoholic resents what he considers sham criticism. He is fully aware of the repercussions of his behavior, his present lack of responsibility on the job and with his family. He does need intelligent, humane understanding, combined with knowledge and awareness, to help him recognize and accept his illness. This I found in the Foundation's program. With the completion of therapy at the Foundation, I was introduced to Alcoholics Anonymous and joined the group of my choice. So now I have my A.A. activities and also the continual support of all the staff of the Foundation. This team has kept me sober for five years; and not only sober, but happy and contented, and leading a meaningful, useful life as well.

A drunk who had been wandering around Times Square finally went down into the subway at 42nd Street. About half an hour later he emerged at 44th Street and bumped into a friend who had been looking for him.

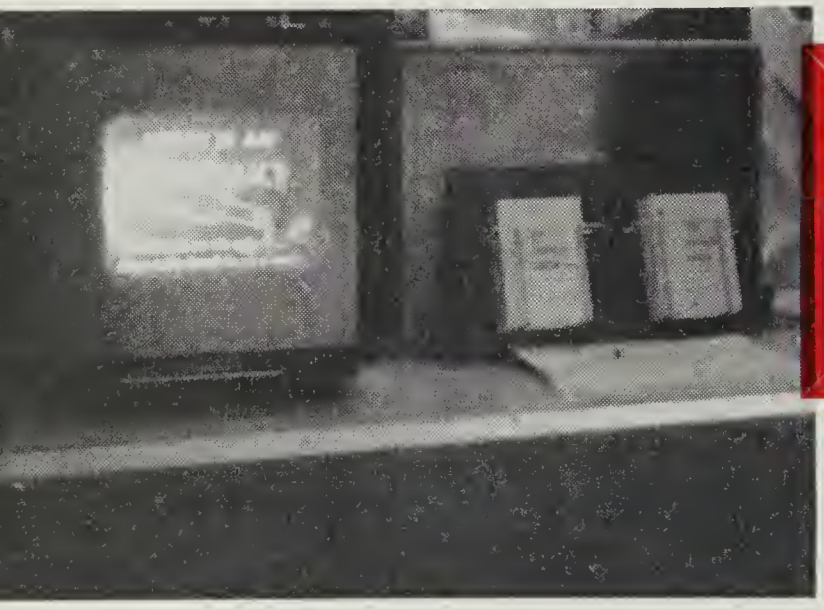
"Where on earth have you been all this time?" the friend asked.

"Down in some guy's cellar," the drunk answered, "and, boy, you should see the set of trains he has down there."

—from the AA Grapevine



Governor Hodges Issues Proclamation . . . . . "Operation Saturation" For Providin



Tel-A-Story Display In Winston-Salem

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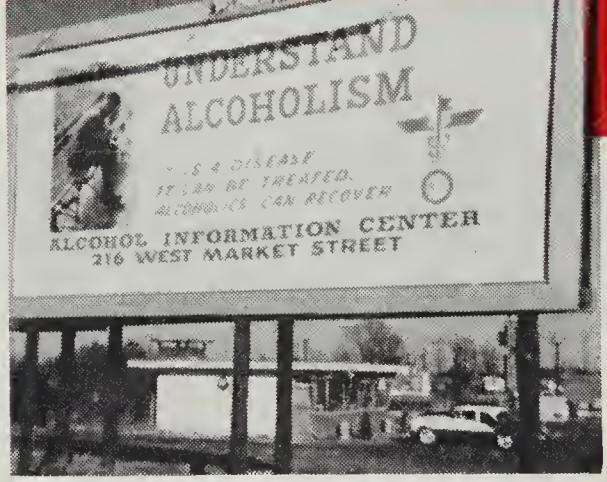
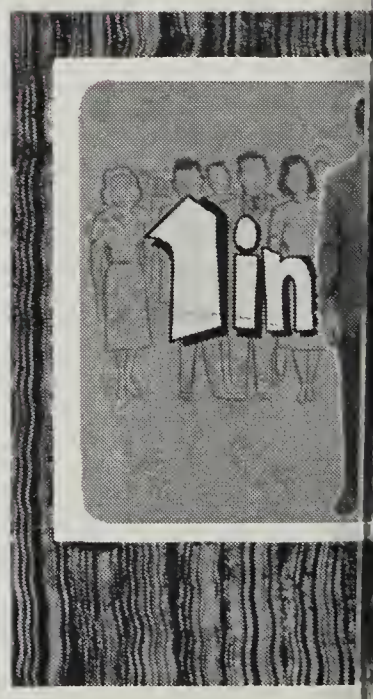
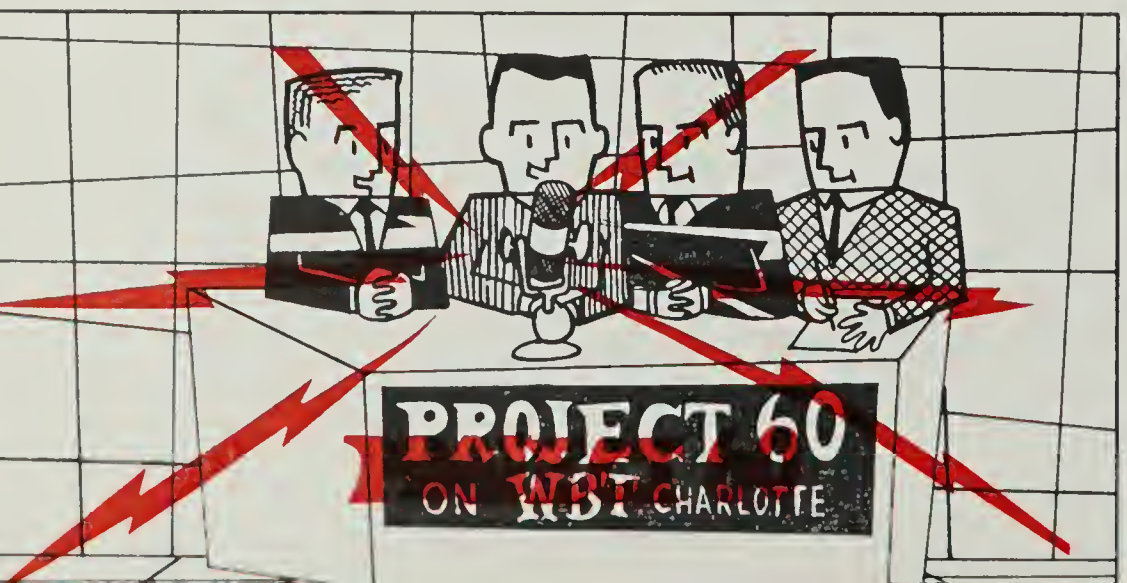
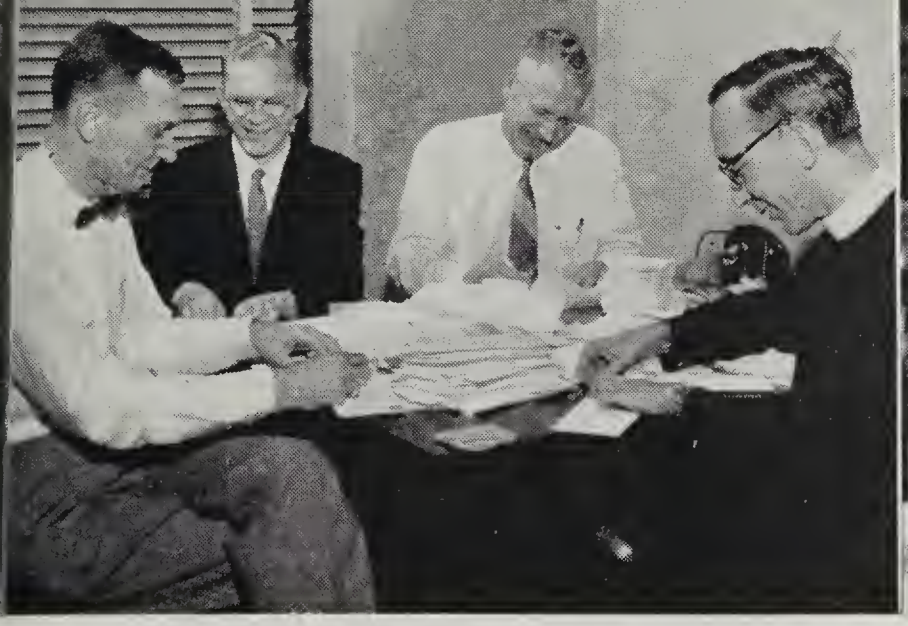
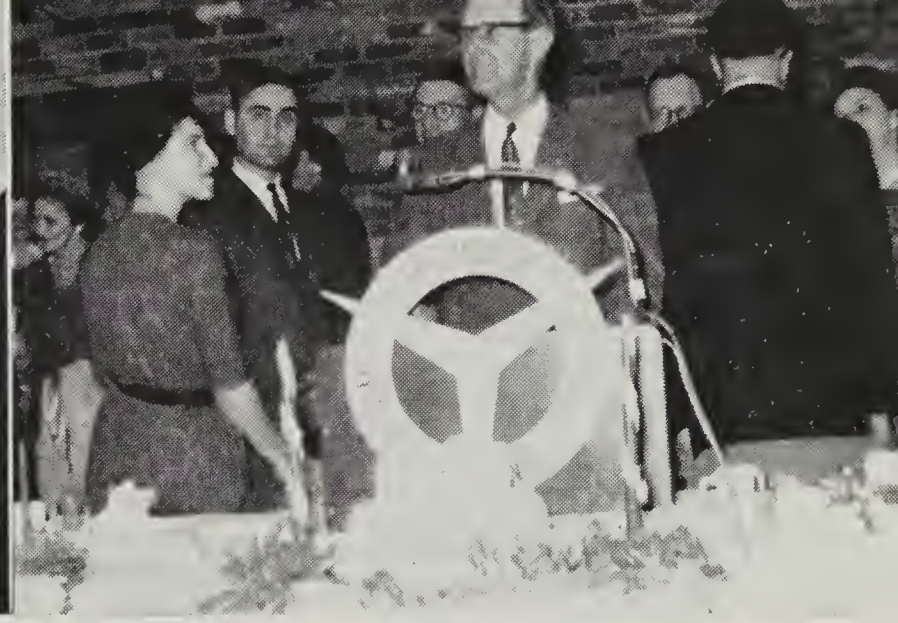




Alcoholism Information Center And Billboard In Greensboro . . . . . Inside And







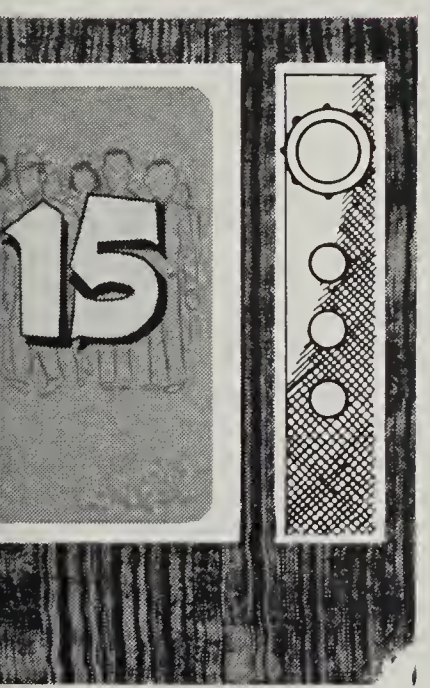
nformation On Alcoholism In Asheville . . . . . Celebrating The NCARP's 10th Anniversary

Information Week

Carolina

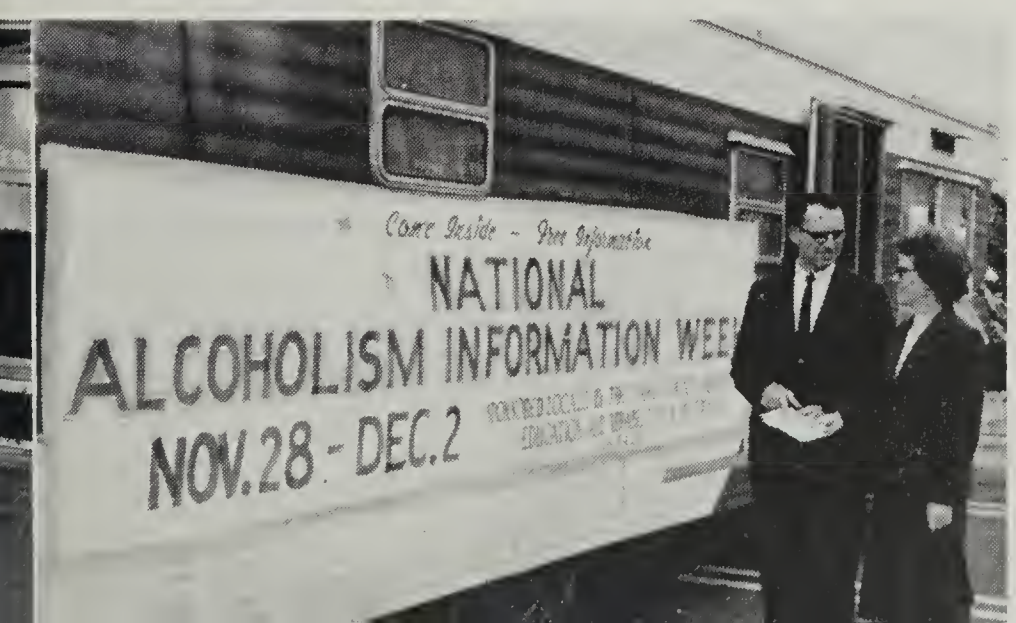
-December 2

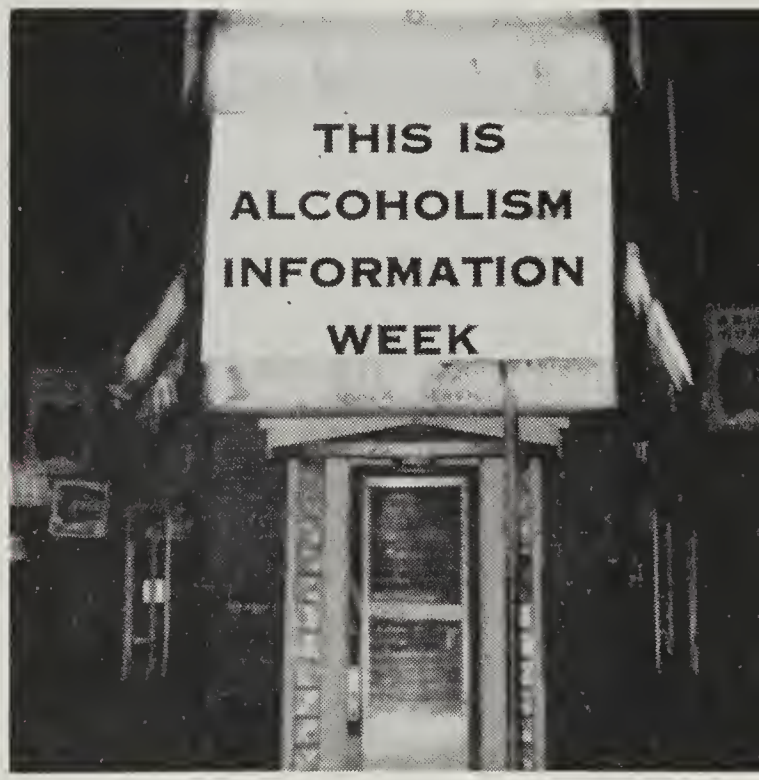
Used State-wide



Reidsville Information Booth

side Raleigh's "Information Trailer" . . . . . .





At Five Points In Durham

Alcoholism Information Week Observance Will Be Held Here

Alcoholism Information Week will be observed next week in Durham under the sponsorship of the Durham Council on Alcohol-

Mayor E. J. Evans, in a proclamation issued today officially endorsing the observance, pointed out that "alcoholism afflicts di-

tegration of family life. ic attrition to the indiv the community is an and

Local Alcoholism Information Week Dates Announced

Alcoholism Information Week has been proclaimed in Durham as the week of Nov. 28 through Dec. 2, 1960, by Mayor E. J. Evans.

The national observance will be

Ike Proclaims Alcoholism Week

NEW YORK (AP) — President Eisenhower has proclaimed next week Alcoholism Information Week.

In a statement issued here Friday by the National Coucil on Alcoholism, Inc., the president said: "In terms of suffering inflicted on the victims and their families, alcoholism ranks among the nation's most serious health

Alcoholi Week Pl Announ

Alcoholism, a disease flicts more than fiv Americans, will be nationally Nov. 26 thr as Alcoholism I Week is observed by on of the President. Locally the week arked by an open Alcoholics Anonymous n War Memorial Tow ay. One of the princ rs will be a forme rom Charlotte.

Throughout the week vill be in City Hall with attendants to dis ure and slides, and gi ion on alcoholism to eek it. Volunteer wor Junior League, Keele

Governor Launches Campaign Against Major Health Threat

RALEIGH — Governor Luther Hodges Monday launched a state-wide campaign against a major

through December 2 "Alcoholism Information Week" in North Carolina

Governor Proclaims Week on Alcoholism

Raleigh, Nov. 29 — Governor Luther Hodges has launched a state-wide campaign against a major health threat by proclaiming November 28 through December 2 as "Alcoholism Information

Understanding Of Problem Needed

Alcoholic Is S But Can Be Ai

EMOTIONS AND PHYSICAL HEALTH

An enlightening discussion of psychosomatic medicine erases some common misconceptions and reaffirms the concept that emotions influence the state of bodily health.

ONE of the great advances of modern medicine is the increasing recognition of the importance of emotions in influencing bodily health. This view recognizes that mind and body work together as one, with the body reacting upon the mind, and the mind upon the body.

The knowledge that illnesses must be considered and treated in relation to the whole person forms the basis for psychosomatic medicine. Much has been written about this concept, but much has been misunderstood. Let's examine a few popular misconceptions.

After listening sympathetically to a neighbor's detailed account of her latest symptoms, a Mrs. R. said: "Just you forget about it, my dear; it's probably only psychosomatic. You know, that's when you imagine you're sick. I heard a very interesting talk about it last night on the

Courtesy of Metropolitan Life Insurance Company

radio."

Tom, washing up after work, called over to his friend, "Say, Joe, about those backaches of yours. I read somewhere about this psychosomatic stuff. They say it's all in your head. I bet if you take a few days off from the job, you'll forget about them and come back as good as new."

And when Mr. J. was told that his wife's illness was emotional in origin, he said to himself, "Well, that's a relief, anyhow. If it's only psychosomatic, it can't do her any real harm."

Mrs. R. meant to reassure her neighbor but she fell into the all to common error of thinking that psychosomatic illnesses are nonexistent ones. This is simply not so. People feel pain just as intensely whether the cause is physical or emotional, and failure to seek professional advice at the first warning sign of trouble can, and often does, lead only to more serious difficulty later on.

Like Tom, many people now have the mistaken idea that a psychosomatic illness is one that is "put on" or made up, that if the patient would only forget about his ailment, it would quietly and quickly disappear. Another common—and equally false—belief (Mr. J. had this one) is that since psychosomatic has something to do with the mind or the emotions, such illnesses cannot cause any physical damage. In order to see why these notions are untrue, let us look first at some of the common or garden variety effects of emotions on our body—not in illness, but in everyday situations with which we are all familiar.

Doctors base their knowledge that emotions play an important part in many types of physical illnesses on facts with which we are all familiar. In everyday situations all of us have experienced some of the effects of emotions on bodily functions. Most of us can recall blushing when embarrassed. Or having a tight feeling in the chest or a weight in the pit of the stomach before an examination. These are normal reactions of the body to specific situations, and are beyond the control of our will power. They generally disappear quickly once the cause is removed.

These bodily changes occur because emotion is really meant to make us act. Fear, for example, makes some of us tense. When this happens, it, in turn, leads to certain physiological and chemical changes in the body. Adrenaline is released which causes the heart to beat more rapidly. The muscles of the stomach and intestines contract, forcing the blood out into the general circulation. The rate of breathing is increased, and other changes occur which are meant to gear the body for action—either to run or fight.

Knowing how these normal everyday emotions influence body functions, we are better able to understand how strong and persistent emotional conflicts may over a period of time disturb the working of body organs, such as the heart or the stomach. It is believed that in some cases they can eventually result in actual change in the organ itself.

Rapid heartbeat is a familiar part of many emotions. In some people when the emotional tension is prolonged, palpitation of the heart may occur so readily that the person suffering from it may no longer be aware of the emotion that originally started it. He then becomes filled with new fears, now worrying about whether his symptoms mean that he has a serious disease. Worry can influence the severity and duration of any illness.

Sometimes a person's emotional conflicts are so difficult for him to accept that he represses his feelings

altogether, and is no longer consciously aware of them. Often what seems to be a purely physical illness stems from a hidden wish to accomplish an end quite different from the one obviously demanded by the situation, and one which the patient is completely unaware of. The little boy who vomits before going to a new school, or the woman who develops a headache an hour before a tiresome party may well be examples of the unconscious mind's protest against something the individual does not really want to do.

Studies show that almost 50 percent of all people seeking medical attention today are suffering from ailments brought about or made worse by such emotional factors as prolonged worry, anxiety, or fear. Emotional tensions often play a prominent role in certain kinds of heart and circulatory disorders, especially high blood pressure; digestive ailments, such as peptic ulcer and colitis; headache and joint and muscular pains; skin disorders; and some allergies.

Physical distress can often be a kind of body language to express emotional troubles that have been repressed. Some of our most common expressions show that we all know something of this body language of the emotions. "He burns me up"; "This is more than I can stomach"; "That makes my blood run cold"; "You give me a pain in the neck"; "Oh, my aching back" are only a few of the many examples of this awareness that is found in our everyday speech.

A woman developed severe and frequent headaches for which no physical cause could be found. Finally, in trying to establish just when the headaches began, her physician learned and was able to point out to her that they first began about two years previously, shortly after a much disliked sister-in-law had moved in with her. The patient had never openly expressed her feelings but had kept them bottled up inside her. The tension had to come out somewhere—and it did. It expressed itself in the form of violent headaches, which finally disappeared when the cause was fully understood.

A man suffered more or less constantly from heart palpitation and was convinced that he had a serious heart condition, although careful examinations revealed no organic involvement. He was having increasing difficulty in breathing; his chest felt heavy. With the doctor's help he was finally able to recognize some of his emotional conflicts. His relationships with his father (with whom he was in business) had never been harmonious, but the patient felt he must keep all such troubles to himself. He *did* have a load on his chest—a load of unhappiness, confusion, and guilt. When this man was helped to resolve his conflicts, the heart symptoms disappeared and there were no further recurrences.

A young woman consulted a physician because she was experiencing great difficulty in swallowing. No organic cause could be found. She revealed many facts about her life, however, that gave her and her doctor a clue to the real cause of her complaint. She was outwardly a mild person and her family and friends had always taken advantage of her. She could always be counted on to baby-sit or to contribute more than her share to the family's expenses. She never protested against the excessive demands made on her, but inwardly she raged at the injustices she was forced to swallow. Her physical symptom was an expression of what she was unable to put into words, or even to admit to

herself.

Discovering the causes of illnesses in which there are emotional factors takes time and skill. A complete physical check-up must, of course, always be made, but other kinds of information are equally vital. The doctor needs to know many details about the lives of his patients and their emotional responses to various life situations. With this knowledge he can help them become aware of those fears and worries that may have caused or contributed to their illness. Recognizing the causes is the first step on the road to cure.

Because of the new knowledge about the emotional factors involved in many types of illness, there is less reason than ever for neglecting to consult a physician at the first warning sign of trouble. Pains and ailments of whatever origin can now be treated with greater hope of success than ever before if brought to the early attention of the doctor, or a specialist or clinic recommended by him. More and more doctors, aware of the connection between certain physical ailments and the emotions, are able to discover these conditions and to treat them successfully by helping the patients to understand them and live with them peacefully and without conflict. In some cases the doctor may wish to call upon more expert help. Mental hygiene clinics, child guidance clinics, family service agencies, and psychiatrists with their assisting psychologists specialize in helping to get at the root of emotional disturbances.

It's not wise—it's definitely unhealthy—to keep emotional tensions bottled up. Instead, we should look for the most reasonable way to work them out. For some of us, just talking over our problems fully and freely with a sympathetic friend or advisor helps to clear the air. It can often help to relieve any feelings of guilt we have about our own disagreeable thoughts and feelings when we discover similar ones in others. Sound health habits and creative outlets and hobbies which substitute physical or mental activity for emotional "stewing" are important for us all.

We can all in our own way practice an important bit of preventive medicine by applying this new knowledge to our children. Childhood is not always the happy, carefree time of life we like to imagine it was on looking back. Most of us have forgotten many of our childhood tragedies because they were too painful for us to remember. But we can help our children by learning to become more sensitive to their emotional needs and to see, insofar as it is possible, that they are free from undue worry and tension.

It is not emotions that are at fault when we refer to emotional problems. Rather it is the way we handle our emotions that can often cause problems. For emotions are not bad or undesirable in themselves—without them we could accomplish little in this world. It is not our job to help our children hide their emotions; it is our job to help them use their emotions constructively. We can help when we give them appropriate opportunities to express their feelings openly instead of having to bottle them up.

And when we show our children our love and give them our sympathetic understanding, we help, too, to give them a large measure of protection against many of the disturbing conditions so common among adults today. We have given them physical immunization against many of the common childhood diseases. Now we must try to give them a large measure of "emotional immunization" as well.

THE STATUS OF ALCOHOLISM—

Where Do We Go From Here?

By MARVIN A. BLOCK, M.D.

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In the field of alcoholism, it behooves all of us to carry out the precepts which we try to teach others.

A great deal has been written and stated about alcoholism. One can hardly peruse a periodical today without seeing somewhere in it a reference to this disease. It has become a popular subject of discussion. There are many statements about it from various sources, both lay and professional. Let us consider some common statements made by authoritative sources which have become bywords in our literature.

Alcoholism Is A Disease

Late in 1956, the American Medical Association, at its meeting in Seattle, placed before its House of Delegates a resolution stating that alcoholism is a disease properly within the purview of medical practice. It was adopted unanimously by the House of Delegates. This was official acceptance by the greatest medical organization in the world that alcoholism is a disease. Subsequent to that action, the same type of resolution was passed by the American Hospital Association. The same premise long ago was accepted by Alcoholics Anonymous, a fellowship of over 200,000 people who are suffering from this illness. While psychiatry for the most part looks upon alcoholism more as a symptom of an underlying disease than as a disease itself, it does recognize that in such cases the symptom becomes of sufficient importance to be conidered an entity which must be treated. Psychiatrists agree that one must recognize and treat alcoholism, at least until the underlying basic mental problem can be reached.

In all these references, however, we are dealing with understanding by enlightened professional people, or the patients themselves who suffer from this disease. Naturally, these particular people wish to study and learn about alcoholism. They have a special interest in this field, and because they are trained professionally to do so, or because they have a special interest, their minds are open.

However, even all of these people do not feel exactly the same way about alcoholism. Not all of those suffering from alcoholism look upon it as a disease. Only those who want help and feel that they should have help recognize that their problem could be an illness. Many professional people with varied backgrounds still refuse to accept alcoholism as a disease, and unfortunately too many of the people suffering from the illness, as well as a great part of the public, have not accepted it.

When I say that the majority of the patients and the public at large has not accepted alcoholism as a disease, I do not mean they have actually made such statements. Conversely, various polls have indicated that the people questioned about alcoholism say they do believe it is a disease. In my opinion, however, this is an intellectual acceptance of the problem, and only on an intellectual basis do they accept it. Emotionally, many of these same people reject alcoholics, and if one rejects an alcoholic emotionally, he rejects alcoholism as a disease, despite his statements of acceptance. Witness the poll taken in one western hospital where alcoholics are accepted as patients without hesitation.

The majority of the nursing personnel, in a questionnaire specifically designed for them, stated they believed that alcoholism was an illness, that alcoholic patients were entitled to hospital care, that they are not always troublesome, that they respond well to treatment, and that they are worthy and capable people. Most of the nurses felt that they properly belong in general hospitals, and should receive the same treatment as any other sick patient in the hospital. On further questioning, however, with specific queries designed to uncover the emotional reaction to such patients, a surprising number of the same nurses indicated that they did not care to nurse such patients, would rather that they were not on the hospital floors, and felt there was indeed a moral problem with these patients. This interesting survey of this particular hospital appears in a published monograph. It is quite illustrative of the statement which I made previously, that intellectual acceptance does not necessarily mean actual acceptance.

Physicians' Views

In the medical profession, this same type of reaction is true to a considerable extent. An increasing number of physicians is willing to grant that these people are sick and deserve and should have treatment, both in the hospital and in their private offices. Further discussion with the same physicians, however, discloses that they do not have sufficient time to spend with such patients, that they would rather refer them to other agencies or disciplines, and that once the acute stage of intoxication is past, there is little that physicians can do toward helping these patients. General practitioners, who otherwise demonstrate considerable compassion toward all sick people, lose patience with alcoholics because they are so frustrating and time-consuming. Even among psychiatrists, one often hears that alcoholics are refused consultation because of their untoward behavior. Still, most of these physicians are willing to concede that alcoholics are sick people.

Patients' Feelings

How about the patients themselves? It surprises me to find how often among these patients there occurs the intense feeling that they have been derelict, weak, and guilty. They speak of alcoholism as a disease, but their attitude is both wistful and wishful, each hoping against hope that he is only a sick person and not an evil one. Many of them believe that they are sick, but here again, it is only on an intellectual basis. Emotionally, they feel guilty, and when questioned closely, many will admit that within their own hearts they feel that this is a moral weakness. The mere mention of the possibility of a mental problem panics them, and their fear is that it is a result of their drinking rather than a basis for it. The spouses of alcoholics are prone to vacillate in their attitudes, depending upon their particular emotions at the time of discussion. While still economically dependent upon an alcoholic spouse, a man or wife may often retain sufficient affection for the patient to consider his or her spouse a sick person. As the illness progresses, and the patient becomes more intensely ill, his actions may become more difficult; then the spouse is less willing to accept him as a person with an illness. Finally, when patience is at an end, the trouble ceases to be a disease, and becomes a dereliction from which the spouse wishes freedom.

And so while the statement "alcoholism is a disease" has gained in

popularity, and is accepted intellectually by most people, actual acceptance of the affected person himself is a long way off. Lip service is not enough. Acceptance of alcoholism as a disease will come only when the stigma has been removed and there is greater understanding of the basic problems.

A Public Health Problem

Alcoholism is a public health problem. Here, again, we find a popular statement. The premise has been accepted by government agencies, public health agencies, lay health agencies, social workers, sociologists, and many other professional people. Those particularly interested in this field, of course, have made this statement over and over. How much convinced are they? Intellectually, they speak about it, write about it, and discuss it at various levels of government and education. How many of these agencies, however, are willing to champion the cause of the alcoholic patient when it comes to appropriation of funds for education, diagnosis, treatment, and research? Sometimes a token appropriation is made to satisfy those proponents who have worked in the field. Often, it is made through pressure brought about by one individual who is particularly interested in the subject because of a personal experience. However, the money, spent in research on alcoholism, is woefully inadequate. Compared to the funds available for the study of other diseases, the amount devoted to the problem of alcoholism is infinitesimal. This is true in spite of the fact that millions of people in this country are afflicted with this illness, and that they number many times that of the other diseases being studied. As a matter of fact, in many areas of the country there is tremendous resistance against expenditures for research on alcoholism by those who feel that there are other areas of health which are of greater importance. It would be presumptuous of me to state that research on alcoholism should take precedence over other diseases, but it is reasonable to expect that a disease which involves such a tremendous number of people annually and eventually kills so many, and which, in my opinion, is preventable, should have as little research as it does.

A Social Phenomenon

Alcoholism is a social phenomenon. In this, we have another popular statement made by sociologists, historians, and ecologists. In reviewing the incidence and progress of this disease, I think that a great deal can be said in support of this statement. If this be true, then the same forces which brought about this sociological phenomenon could be modified if the proper methodology were employed. If such modification is impossible, or impractical, then new forces could be applied with the objective of producing other sociological phenomena to counteract the first. As of today, however, we find alcoholism a frighteningly prevalent disease in a culture which encour-

ages drinking of alcoholic beverages and which has an appalling tolerance for drunken behavior. "There, but for the grace of God, go I," seems to be the attitude of most people when drunken behavior is witnessed. There is a hesitance and a fear of censuring such behavior. One does not wish to be classified as a "square." One does not wish to be called a "bluenose." "He is not hurting anyone." "He is harmless." Such statements are common. They may be true for the most part, but for that one out of 15 persons who might be an early alcoholic, they are the grossest of misstatements. If we could only be sure which one of the group was susceptible, we could be very generous about the other 14. To the one susceptible, however, and early in the disease it could be any one of the group, the intoxicating behavior may portend tragedy for himself and his family.

Changes in Cultural Standards

A cocktail party is an accepted social function, and a very pleasant one. A preprandial drink can be a very pleasant preface to dinner. However, there seems to be a prevalent idea that just to drink is not enough. One must feel the drink. One must attain the feeling of euphoria, or why start at all? Do not misunderstand me. I am not against drinking. I do not favor prohibition. I am not anti-alcohol. However, I do think that some changes could be made in our cultural standards. We should not encourage drinking thoughtlessly as though it is completely harmless. We must always keep in mind that one out of every 15 adults is suffering from alcoholism in one of its stages. The statement that "One won't hurt you," can be a reassurance that applies to 14 others, but a false assurance to the fifteenth that could spell disaster.

A Human Tragedy

Alcoholism is extremely insidious in its onset. In its early stages, it cannot be differentiated from social drinking. Its victims are the last to recognize it. It engenders defensive attitudes in those afflicted, and even those close to him. It becomes overtly manifest usually only after a long period of involvement. It brings misery to its victims and their families and friends. It means economic disaster for those involved. For all of us, it is an expensive problem because it affects us all economically. Unfortunately, there has been no appreciable diminution in the prevalence or the effect of this disease in the last ten years, despite intense, educational efforts by those interested. It is true that during this period many alcoholics have achieved recovery. Many have been rehabilitated to new and healthy lives. Unfortunately, however, new ones have taken their place. In spite of the tremendous strides which have been made in the direction of recovery and rehabilitation, no great inroads on the entire problem have been made. But it is not as discouraging as this statement might imply. There

is a groundswell to be felt, which presages better things to come. As of now, however, I think that the situation which I have described is a fairly accurate one, a reasonable view of the problem from where we now stand.

Where Do We Go From Here?

Where do we go from here? If alcoholism is a disease, and is accepted as such, then let us treat it as such. Let all physicians, all hospitals, and all nursing personnel realize that alcoholic patients are entitled to adequate treatment without unnecessary moral overtones. Let research in the field be carried on to the same extent as with other diseases. Physicians, clinics, hospitals, and required medications should be available to any of these patients.

In appropriating funds for research and treatment of alcoholism, many states have resorted to taxing alcohol. Such taxes have been earmarked for the problem of alcoholism. Is this not just one more evidence that alcoholism is not accepted as are other diseases? I can see no objection to a tax on alcohol. It can be made as high as the legislators wish. However, I cannot understand earmarking such funds for alcoholism. Why not put these same funds into the general treasury? If alcoholism is a disease, let the funds for its study be taken from the general treasury, just as funds for other diseases are provided from the same source. Certainly, it is agreed now that alcohol is not the cause of alcoholism. Why differentiate between it and other diseases in earmarking funds for its study?

Alcoholism is a public health problem. If alcoholism is a public health problem, and is accepted, let the public health authorities study its epidemiology, emphasize its early detection, and recognize the communicability of this disease, as has been done with other public health problems. Let these authorities provide the facilities and the money for proper research about alcoholism, and let the amount of money be comparable with its prevalence. As can be expected, this can require a tremendous amount of money. With such appropriations already made, and more available, sufficient research could be made into the physiological, biochemical, microbiological, and metabolic fields to determine those physical factors which differentiate the alcoholic from the normal person. Such studies must be done by a highly specialized team of scientists, working directly with alcoholic patients in an environment which would be conducive to extensive investigation in this specialized field. Answers to such problems do not come quickly or easily. It is necessary, therefore, that sufficient sustained interest and effort be brought to bear to produce results. In many areas, public health personnel are doing all this. It should be in every public health program. Sufficient interest must be stimulated among constituents to influence their representatives in various legislatures to

press for research in this tremendous public health problem.

Sufficient study on the epidemiology of alcoholism has not been made in the public health field. I imagine that has been largely due to the lack of funds. The communicability of most diseases with bacterial etiologies is well known. Too little emphasis has been placed upon the communicability of mental or emotional problems, particularly on that of alcoholism. There has been sufficient evidence through history and experience that alcoholism is more likely to occur in families where there has been an alcoholic parent. It occurs more in this type of family than in those free of the disease. It is also conceded that the disease is not hereditary. The communicability of this illness, therefore, becomes one of the important and outstanding problems in prevention as a public health measure. Work along these lines should constitute one of the big efforts of the future. As with any other disease, early detection and treatment gives the patient a much better chance of recovery, than the application of treatment later in the disease. As with many other illnesses, the solution to the problem may not necessarily be the successful treatment of the involved patients, but rather the prevention of future patients. Prevention of any disease is a public health function. This is one with which public health departments must contend.

As a social phenomenon, alcoholism is recognized by many scientists and educators. The cultural forces which have brought about this social phenomenon are varied and many. If such forces have produced such a phenomenon, is it not possible, then, for us to generate new forces, new ideas, new approaches, and new facilities for reversing this result? Ideas, like diseases, are communicable. Whole nations, in a comparatively short time, have been known to change their ways of living. Indoctrination of thoughts, sometimes referred to as brainwashing, sometimes referred to as mass media propaganda, and more often referred to as education, has been known to revise human ideas and methods of thinking. What is right and what is wrong is not always easy to determine. Moral values change. Most of us recognize, I believe, that often these are matters of time and place. What was acceptable generations ago may not be acceptable today. What is wrong in some parts of the world is considered right in others. Morality, therefore, becomes a question of education, training, understanding, and background. Again let me remind you that where no harm results, drinking need not be objectionable.

Intoxication—acceptable or not? It has long been recognized that in certain cultures, drunkenness was not tolerated. The slightest indication of excessive drinking or intoxication was frowned upon, and the individual affected was often socially ostracized. Children learned this early

in life. To such individuals, intoxication was reprehensible. In such cultures, the occurrence of alcoholism was a rarity. It is true that humans will often seek escape from reality by various devices, but where one's background and training has been to avoid alcohol for such an escape, individuals do not resort to drinking.

On the contrary, in other cultures, excessive drinking is often acceptable. Intoxication is tolerated, and in some areas, even encouraged. In such areas, chronic alcoholism is quite common. Omitting for the time being that small percentage of people who are sensitized to alcohol from the first drink, it is conceded that the vast majority of alcoholics become physiologically addicted only after many years of drinking. Training, I submit, is one way of discouraging alcoholism.

The desire on the part of most people to conform sometimes proves an obstruction to their recovery. It is extremely important that all of us realize that many such people are in our midst. It is unfair for us to make their recovery more difficult. Hosts and hostesses must be encouraged to remember that some of their guests may find embarrassment in refusing to drink in a society where it is so prevalent. Under no circumstances should anyone be coaxed to drink alcohol, and a "No, thank you" should be taken exactly as it is meant. "One won't hurt you" is a dangerous statement, and born only of ignorance. The possibilities of error are too great.

Only a few short years ago, when prohibition was the law of the land, drinking by young people became the smart thing to do. I dare say that before prohibition, there had been drinking, even excessive drinking, but one rarely saw young people of high school age indulging, and certainly not girls. Alcoholism, I am sure, also existed. There is no doubt that there was excessive drinking in many social circles. Inebriates, however, were frowned upon, and the alcoholic woman was considered fallen. Mostly, such excesses were found among the ignorant and the uninformed, although I am sure it existed among all classes. During prohibition, however, when it became smart to drink, more and more young people indulged. It was the thing to do, and there was considerable encouragement by everyone to flout an unpopular law. The flask on the hip became popular. It became the badge of the sophisticate. Home brew and the speakeasies were popular evidence of outsmarting the law.

Since these untoward results were brought about by a new way of thinking, would it not be possible to reverse the process? Would it not be possible to make it smart *not* to become intoxicated? Should the slogan not be "If you drink, never drink excessively," and could this not be made the mark of the real sophisticate, the mature person, and the well-adjusted individual? We cannot consider prohibition. This has never succeeded. However, to recognize the excessive drinker or the chronically intoxicated drinker as a poorly adjusted person who needs help rather than a smart and sophisticated one might more properly classify him, and make him and those close to him conscious of the fact that he needs help. It is imperative that we teach everyone that alcohol is a powerful drug, and that when one is in need of such a drug, or becomes dependent upon it, that person is sick, is far from normal or well-adjusted, and that he needs help. Would this not be one way of making everyone more conscious of the existence of alcoholism? This is

another goal toward which we must reach.

Actually, we must concede that alcoholism is but one manifestation of a tremendous mental health problem. In order to combat alcoholism, one must work toward combating the even larger area of general mental health, because it is from this area of the emotionally disturbed that the alcoholic is recruited. If we can improve the general mental health of all, then the chances of any of them becoming alcoholics is reduced. The ability to rear future generations to living in the world, adequately adjusting themselves to its many problems, must be our eventual goal. We live in a highly complicated, intensely competitive, and sadly ununited world. It is unrealistic to lead young people to believe the world to be as we would like it, rather than what it is. To prepare such young people properly, there must be sufficient groundwork laid for facing the realities which they must meet as their lives progress.

There are certain principles which they must learn. They must be taught at an early age that one does not succeed every time, that one must adjust and compromise, that each of us has limitations, and responsibilities. They must be taught that each has these responsibilities which he must carry to the best of his ability. He must learn that the results are not always the best, but that if they are not good enough, there may be limitations to account for them. If such limitations exist, they must be accepted. Children, as well as adults, must be taught that it is important to accept inevitables, and yet in the face of the inevitable, they must still keep trying. They must be taught not to be discouraged easily, not to expect that every problem can be satisfactorily solved. Such education is not easy. It must be carried on gradually from early youth through adulthood. It must be broad-based and extend over all disciplines and all ages.

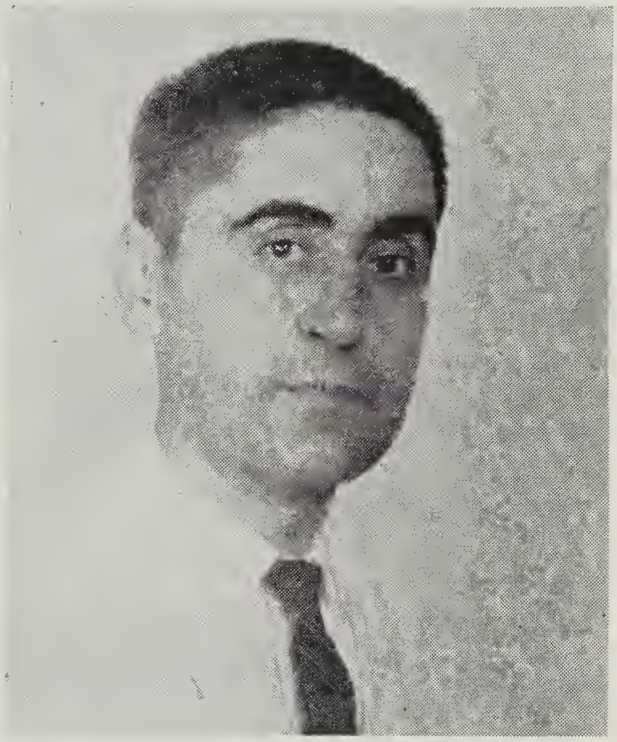
Perhaps the best way in which this can be accomplished is by example. Who can better set such an example than those of us who recognize these precepts? Young people, as a rule, are extremely observant, and see much more and understand much more than we give them credit for. This must always be kept in mind. Children watch adults very carefully, and all too often, the patterns set by adults are followed by children. When these patterns are wholesome, the child benefits. This, then, places a tremendous responsibility upon the adult. This applies not only to parents, but to teachers as well, and here is another area which must be thoroughly explored.

The teaching in the public schools, as well as private schools, must include subjects such as alcoholism. In this teaching, it is very important that the children be taught the truth. There have been so many distorted statements regarding alcohol and alcoholism that conflicts are continually created in the minds of children. To tell a child that alcohol is poisonous or brings about deterioration of brain tissue, or many other such exaggerations as have been taught, and have that same child go home and watch his parents partake of alcoholic beverages creates in the childs' mind a distrust of his teachers. Such exaggerations and misleading statements must be avoided. Children must be taught the facts regarding alcohol and the effect of it. Lessons on this subject must be taught in full without exaggeration. Different cultures have different attitudes toward drinking. These various cultures and their backgrounds must be explained to children, and a tolerance and respect for other

cultures must be learned.

The teacher's attitude in this matter is of extreme importance. The true facts about alcohol and its use in the various cultures must be imparted without personal emotional involvement of the teacher. This can be very difficult for the teacher at first. When there is a background of education and training in a culture other than that of the children who are being taught, the conflict may be the teacher's. However, this tests the ability of the teacher to impart knowledge without involving his own emotions. Teachers must be taught to handle such emotionally charged subjects with an objectivity which is of extreme importance for proper unbiased presentation. They can get this type of training only in schools of education, where programs dealing with the subjects of alcoholism are taught adequately.

It behooves all of us then to carry out these precepts which we try to teach others. We must impart to others with whom we come in contact the knowledge of the subject which we now have. We must teach it as fully and truthfully as we can in the light of the scientific facts as we know them. In spite of the vast uncharted areas which still challenge us on the subject of alcoholism, there are certain facts of which we are cognizant. Various recognized theories can be taught, and the reasons for such theories. This will stimulate thought in those who hear them. More than that, we must lead our own lives so as to set an example for those we teach. If, then, in the light of what we know and what we teach, we can help those whom we are teaching to proper adjustment of living and understanding of the forces which may lead to alcoholism, then perhaps with such enlightenment, we will be able to see where we go from here.



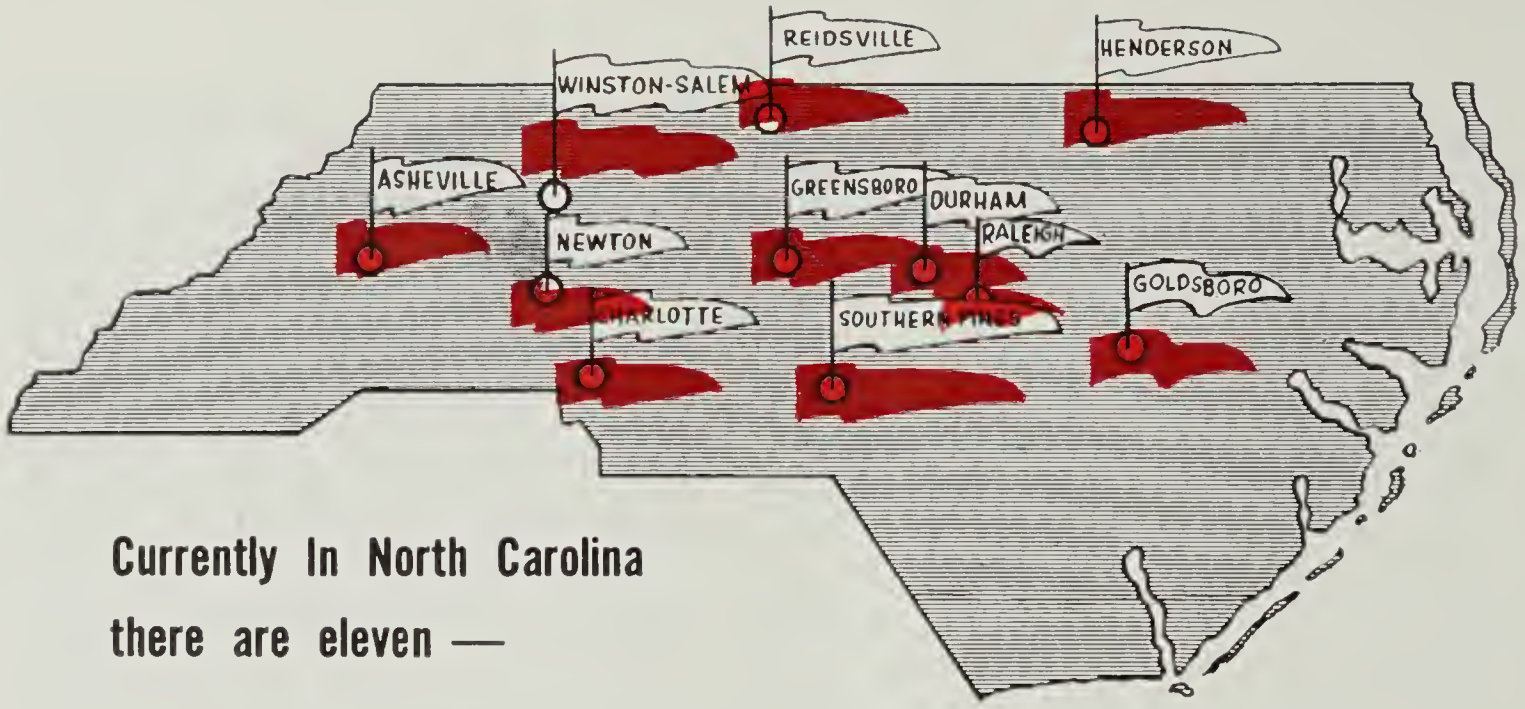
NEW STAFF MEMBER

Staff members at the Alcoholic Rehabilitation Center at Butner, N. C. recently welcomed Dr. Nicholas Pediaditakis, Staff Physician, to the A.R.C. family. Before coming to Butner, Dr. Pediaditakis served as staff psychiatrist for the Fairhill Psychiatric Hospital in Cleveland, Ohio.

A native of the Island of Crete, in Greece, he attended the School of Medicine in Salonica, Greece after which he spent two years in the Army Medical Corps. Later, he came to the United States and interned at Fairview Park Hospital in Cleveland, Ohio.

Following his internship, Dr. Pediaditakis came to North Carolina to serve on the staff of the State Hospital in Raleigh, ventured west to the Colorado School of Medicine for two years, then returned to Cleveland to join the staff of the Fairhill Psychiatric Hospital.

Dr. Pediaditakis hopes to introduce new medicines in special projects with people who have alcoholic problems.



Currently In North Carolina there are eleven —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Don Dancy, Educational Director

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—
Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program
300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 West 4th St., Winston-Salem
Marshall C. Abee, Executive Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120

This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public libarary to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JAN.-FEB., 1961

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Al-Anon: The Answer
Alcoholism and the Family
Half-Way Houses For Problem Drinkers
Alcoholic Rehabilitation in N. C. Prisons
Why Psychiatrists Fail With Alcoholics
Home Reconstruction: A Lifetime Job
Psychotherapy of Alcoholism
Letters to the Program
What's Brewing?

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,

compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a through medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

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INVENTORY

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

CLEVELAND, OHIO: The Cleveland Center on Alcoholism is hoping to begin, in the near future, work on research into the effects of alcoholism in parents on the emotional development of their adolescent sons and daughters. Herman E. Krimmel, director of casework services, will serve as the principal investigator of the project and Dr. Mildred Weiss, director of psychological services, will be co-investigator.

METHODIST CHURCHES STUDY ALCOHOLISM: Throughout North Carolina for the past several months Methodist churches have been conducting a series of study sessions on the subjects of alcohol and alcoholism. ARP Educational Director George H. Adams has spoken to many of these church groups and will continue to do so during the upcoming weeks. Among the church groups to whom Mr. Adams has spoken are the First Methodist Church in Washington, N. C.; the Angier Methodist Church; the Methodist Church in Laurinburg; Garner Methodist, Lillington Methodist and the Wesley Memorial Methodist Church in Raleigh. Other churches which are scheduling study sessions in the upcoming weeks are the Trinity Methodist Church in Red Springs; the Methodist Church of Draper; Fletcher's Chapel near Durham and Wynnewood Park Methodist in Raleigh.

NEW YORK CITY: The Consolidated Edison Company of New York City has conducted a ten-year follow-up study of its alcoholic rehabilitation program. Results were reported in the **Journal of Occupational Medicine** by Dr. S. Charles Franco, executive medical director. The company officially recognized chronic alcoholism as a medical condition in December of 1947. The study roughly covers two periods: 1948-1951, when medical facilities for adequate rehabilitation were not available; and 1952-1957, when such facilities became operable. Overall, during the period 1948-1957, 398 cases of a drinking problem were recognized and an average of 40 new cases each year among 25,000 employees was found. Fifty-one percent of the employees under rehabilitation were able to maintain their jobs. Sixty percent of those who had the benefit of special medical treatment were successfully rehabilitated when reviewed over a follow-up period of more than five years.

CANADA: It is estimated that there are more than 200,000 alcoholics in Canada with an indirect effect on some 1,000,000 other people. Because of this, alcoholism is rated the fourth most serious health problem and the most serious social problem in Canada today.

NEW YORK CITY: The 1961-1962 Executive Committee of the North American Association of Alcoholism Programs held its first meeting in New York City January 9-13. Among those attending was Dr. Norbert L. Kelly, associate director of the NCARP, who was elected second vice president of the NAAAP at the association's eleventh annual meeting held last Fall in Banff, Alberta, Canada. We congratulate Dr. Kelly on this honor and wish him, and his fellow officers, a happy tenure in office. The other officers are John R. Philp, M.D., president, California, U.S.A.; J. George Strachan, first vice president, Alberta, Canada; and George Dimos, secretary-treasurer, Oregon, U.S.A. Other members of the Executive Committee are H. David Archibald, past president ex-officio, Ontario, Canada and Ernest Shepherd, member-at-large, Florida, U.S.A.

LONDON, ENGLAND: An attempt by highway authorities to cut down on accidents due to drunken driving is running afoul of the Britons' traditional gambling instinct in northern England, the **New York Times** reported. Reflex testing machines were placed in fourteen of the 167 pubs in the town of Carlisle by the Royal Society for the Prevention of Accidents. The purpose was to enable customers to test their own level of intoxication before starting home. It was a good idea but, unfortunately, the gamblers took over and the machines were used primarily to referee bets on drinking capacities.

JAPAN: Vending machines for alcoholic beverages have appeared in several large cities in Japan. One side of the machine dispenses a drink called "shochu"; the other side pours out "sake", a rice wine. Since these beverages sell for about $.02 and $.14, respectively, virtually everyone may be able to purchase an alcoholic beverage.

ARTICLES OF INTEREST: In the December, 1960, issue of **Today's Health,** published by the American Medical Association, there is an article by Howard Earle entitled "They're Helping the Alcoholic Worker." In this particular article, the author describes industry's new approach to the alcohol problem among employees. Two other national magazines have recently carried articles pertaining to alcoholism. **Consumer Reports** published an article entitled "Alcoholism—The Problem Brought Up To Date" in its November, 1960, issue and the **Reader's Digest** carried a condensation of "My Trials As A Non-Drinking Alcoholic." The latter article appeared in the **Saturday Evening Post** in 1959 and recorded what a doctor learned about "the demanding and somewhat lonely art of abstinence in a socially drinking society." These three articles indicate that the editors of our national magazines are becoming more and more aware of the emergence of alcholism as one of the major health problems in our nation.

Sociology Paper

I am a freshman at the University of North Carolina and for our sociology class we are required to write a 1,000 word paper. I have chosen the topic, "Alcoholics Anonymous." My professor, Dr. H. Douglas Sessoms, has suggested that I write you for information. Please send it as quickly as possible.

Lois Ann Oakley
Chapel Hill, N. C.

Student Writes

In our health course this six weeks we are studying alcohol. Would you please send me any available pamphlets on this subject. I need this information as soon as possible. Would you please send it at your earliest convenience? Thank you.

Anne Lowe
Asheville, N. C.

Al-Anon Member

I am active in Alcoholics Anonymous and Al-Anon and would appreciate being placed on your mailing list for *Inventory* as I find it very helpful.

Anonymous
Fairboult, Minnesota

Family Problem

Please send me some information on alcoholism. I have a problem in my family and would appreciate the information. Thank you.

Anonymous
Charlotte, N. C.

Nurse Writes

I would like to be placed on your mailing list for *Inventory*. I feel that the articles contained in your journal are very useful in helping nurses with their attitudes toward alcohol and the alcoholic patient.

Evelyn A. Kile, R. N.
Nurse Supervisor
State Department of Health
Manchester, Iowa

Literature Request

Please put my name on your mailing list for *Inventory*. Also, please mail me several copies of the "New Cornerstones" and any other literature you make available for the rehabilitation of alcoholics. I want to use the literature in the local shirt factory of which I am plant manager.

Julius Schutzman
Garland, N. C.

Spurs Local Council

For some two years now our family has been receiving *Inventory,* and I wish now to express our thanks to your Alcoholic Rehabilitation Program for the wealth of knowledge about what-to-do about alcoholism contained therein. It was due to *Inventory* that our first thoughts of a local alcoholism council came into being. We sincerely thank you. Also, if it is not asking too much, could our council officers and members receive a copy of *Inventory* as it is published?

Bill Hardwick
Deaf Smith County
Council On Alcoholism
Hereford, Texas

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

WHY PSYCHIATRISTS FAIL with ALCOHOLICS

BY HARRY M. TIEBOUT, M.D.

• *Alcoholism is a disease which must be treated for itself.*

WHILE no one is more convinced than I am that alcoholism is a disease, no one is more appalled than I am at the blithe manner with which the concept has been received and the easy use to which it has been put. To paraphrase Winston Churchill's famous war statement, I could say, "Never has so much been done on so little with so much hullabaloo."

I can say this quite frankly. I was in on the early hullabaloo and did a certain amount of it myself. I cannot help but feel that the whole field of alcoholism is 'way out on a limb which any minute will crack and drop us all in a frightful mess. I sometimes tremble to think of how little we have to back up our claims.

Yet actually I would not have it otherwise nor do I think it could have happened differently. All movements get under way through some one or some group taking a chance. That has to be. The only danger comes from failure, later on, to see things in perspective. We should never be fooled by our own ballyhoo into any false sense about our accomplishments. The need to do something about alcoholism is admitted; the main question concerns the tools we have available to carve out satisfactory results. To me they still seem pretty crude and makeshift.

This fact, while it is to be deplored, cannot be used to condemn. It is an outgrowth of forces over which we as a group had little or no control. The field, like Topsy, just "growed." First it was the Research Council, then it was the people at Yale and the mighty impetus of Alcoholics Anonymous. Finally it was the organizational and educational work of the National Council on Alcoholism. The question now is what do we face—those of us who are actively engaged in meeting the problem?

Have we not almost promised to do a job with very little real right to say anything more than "we'll try"? Have enough of our energies been devoted to helping us get down off that limb—toward establishing a reliable body of data and experience which will enable us to develop competent practitioners in the field of alcoholism? I very much doubt it.

There are undoubtedly many rea-

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sons for this failure to establish reliable information about alcoholism. One, however, strikes me as of great importance because it is subtle and not generally recognized: the fact that persons who enter the field of alcoholism come from other fields. More than they realize, they are bringing something to the field and have little expectation of learning anything from the field, nor do they feel any particular need to do this. They have already been taught; now they will apply what they know. It does not take them long to realize that what they know does not amount to much when it comes to handling alcoholics.

Two reactions are then possible. The individual either changes and begins to function or he remains rigid and becomes discouraged, disillusioned, and skeptical about the prospects of working with the alcoholic. The unfortunate truth is that, as far as psychiatrists are concerned, a sizeable majority never quite make the grade. They always seem like fish out of water.

Naturally I have given thought to this new phenomenon. My explanation lies in the point of view they bring with them. They come equipped with training and they busily engage themselves in trying to utilize their equipment. Rarely does it function well in the field of alcoholism. The question is: "Why, when that same equipment serves well in other areas, does it fail them with alcoholics?"

I think this is an important question. One reason for the lack of specific knowledge about alcoholism is the dearth of clinicians who remain in the field long enough to obtain any feeling for the condition. They seldom get beyond the dabbling stage and are in no position to add to our knowledge. In the summary of the research meeting held in October 1954, Diethelm stated that most investigators in alcoholism reported once and then quit, confirming my own observations. We must ask the question, "What happens to produce this repeated development?"

This question and its predecessor, "Why does the well-equipped psychiatrist fail with alcoholics?" can, I believe, be answered by the same reply. Before trying to formulate an answer, let me set the stage with some background material. The present day psychiatrist is steeped in the methods of modern medicine. Whenever you encounter illness, you search for the cause, then you treat the cause and cure the illness. That is just as true for psychiatric ailments as it is for physical conditions. Treatment is directed toward etiology.

When a person so oriented hits alcholism, he is out of luck—only he does not know it. What happens is that he by-passes the disease and looks for causes; he ends up talking about earlier experiences and never gets close to this patient or the illness. His training is a hindrance instead of a help. He must revamp his sights or he is lost.

At a meeting last winter, a psychiatrist thoroughly trained in the modern approach read a paper in which he outlined some of the thinking he had to scrap before he could operate comfortably with alcoholic patients. He stressed mostly the need to give up history-taking and deep search for causes, particularly at the start of any therapeutic relationship. During the discussion which followed, he was chided by a more orthodox colleague who was a bit horror-struck at the heresy about history-taking. The reply of the reader of the paper was in my eyes perfect. He said in part, "I used to think a full history was necessary but I found it didn't work; I had to change

my mind." Needless to say this person is continuing in the field of alcoholism and I believe will be heard from again. He did not adhere rigidly to his training precepts; he really accepted reality and to that extent was more effective. Unfortunately, there are not many of his kind.

What happened, of course, was that he shifted his sights and looked at the illness, alcoholism, which he was finding could not be treated by the conventional approach he had learned. He had to formulate a new approach. How he did that I cannot tell you. I can tell you, however, about how I have modified my own thinking in the light of experiences similar to those of the man I have been talking about.

Perhaps the first thing to impress me with the need to change my approach was the routine complaint from patients that their talks with psychiatrists were almost uniformly unhelpful. This was in the earlier days. The complaint was that the psychiatrists never talked about the drinking and seemed to minimize its importance, which was duck soup for the alcoholic, but, in the long run, not very effective. The routine history-taking approach seemed to have many strikes against it.

Then secondly, AA came along with a program to stop drinking; causation was ignored, the focus was all on treatment. Medicine's insist-

ence on treating causes was disregarded, not wittingly to be sure, but the emphasis was on stopping the drinking and helping the individual to achieve and maintain that end. Like the treatment by surgery, the causes were irrelevant in meeting the immediate issues.

In the old days, patients were given remedies such as digitalis to help correct or overcome the symptom, namely, the weakened heart muscle. Remedial treatment nowadays tends to be downgraded as temporizing and superficial. It lacks precision and seems a blunderbuss method. Yet no one is willing to discard digitalis and no one that I know of is going to urge the scrapping of A.A. They both work, they both preserve life, and though neither cures, both provide for the prolongation of life and thus add years of satisfying existence. For people so benefited, interest in causation is academic. The clinician may wish he knew more about causes but he is grateful for the fact that he has a remedy. And almost always he wishes he had more of them.

Similarly, any treatment of the alcoholic must be remedial. There is no present value in getting at the causes and correcting them because the net result of such an endeavor would be to enable the person to drink normally. While such a goal may be achieved in some far off millennium, its attainment in the immediate future is absolutely unlikely. Any therapy devoted to such a goal is admittedly unrealistic; everyone acknowledges that there is no present cure, that the only remedy is total sobriety. The person does not learn how to handle liquor, he stops using it.

The goal of therapy is, therefore, to get the patient to stop taking the first drink. I have found it fruitful to work along the line of why the patient will not or cannot stop taking that first drink. It has led to the concepts of hitting bottom, (adopted, of course, from AA) surrender, compliance, and a recognition of an intractable ego which will not stop for anyone or anything. And strangely enough, in trying to apply the remedy of stopping drinking, I have learned more about the alcoholic and his problem than I ever did when I was concentrating on causes and minimizing all remedial efforts.

Once I concentrated on trying to stop the drinking, I began to focus on the illness itself which took on more and more stature as a disease. Finally, I was willing to set aside my previous experience and center attention upon what was going on that was ill or sick. The clinical situation held my nose to the grindstone and it was from the clinical situation I learned about alcoholism. And I know that as soon as I divorce myself from the clinical situation my source of learning will be gone.

Now is not the time to talk about the remedies we have available. You know them as well as I do. The real problem is to get the individual to take those remedies. Unless one is practiced in handling the various dodges or stratagems of the alcoholic, one gets nowhere. Defense reactions are found in every psychological illness. The alcoholic has the same defenses as others plus a sturdy crop of his own, arising from the special nature of his ailment. Until the practitioner develops some dexterity in penetrating the wall surrounding the alcoholic, he can anticipate little progress.

Articles on how to establish contact with the alcoholic in order to get him to accept possible remedies are scarcer than hen's teeth. Should there be pressure or not is an everyday issue. Do we have any consensus

(Continued on page 31)

AL-ANON: The Answer

BY BETTY WILLIAMS

Mrs. Williams attended Birmingham-Southern College and is a graduate of the Yale Summer School of Alcohol Studies. She is a volunteer family counselor who works with families of alcoholics and Al-Anon groups in Alabama.

For relatives and friends who desire to learn more about how alcoholism affects the alcoholic and those near to him, Al-Anon is the answer.

IT is a fairly well-known and established fact that there are in our country today approximately five million alcoholics and, that on the average, there are four or five other persons whose lives have been disrupted as a result of alcoholism. That's twenty million people who suffer directly or indirectly from this illness. After examining these figures, it is not difficult to determine that not only do we have a large problem in rehabilitating the alcoholic and helping him recover, but that the problem of rehabilitating these other persons—the families and friends of alcoholics—is very extensive, indeed.

Ministers, physicians, counselors, psychologists and social workers all have played and *do* play an essential role in helping the alcoholic and his family. More recently, a relatively new organization particularly concerned with helping the families of alcoholics has emerged on the scene. This organization is known as the Al-Anon Family Groups.

Unlike Alcoholics Anonymous, which was founded in 1935, Al-Anon had no definite beginning. Instead, it sprang up in the years following the founding of AA, and grew gradually—much slower, actually, than did Alcoholics Anonymous. It is only within the past few years that Al-Anon has come of age.

Al-Anon began when AA was still in adolescence—when relatives of alcoholics realized that not only was alcohol changing the lives and personalities of their loved ones, but that *their* lives and personalities were being changed, too. AA could help the alcoholic, but who or what could help the families and friends of alcoholics? The answer: Al-Anon.

This group, consisting of the families and friends of alcoholics, was formed so that those persons close to the alcoholic could better under-

stand him and the problems which he faced. In addition, Al-Anon was formed so that the families of alcoholics could gain better insight into *their* problems, as well. Thus, Al-Anon essentially has a two-fold purpose.

Wives, husbands, parents, employers and friends of alcoholics share a sense of despair over not being able to help the problem drinker. They have feelings of helplessness and aloneness which are inevitable. Families are overwrought with fear, anxiety and shame. They have their hopes built up time and time again, only to have them shattered. They live the golden days of sobriety with zest and vigor and, at the same time, tremble with fear of the next debauch. They have seen their personalities and those of their children change. They have veered from extreme to extreme and yet have never stopped hoping and praying that some day their loved one would once more be himself.

At the same time, many of these people harbor certain feelings of revulsion for the alcoholic. Often they turn their backs on him in disgust. They pity themselves because they have to put up with him, and they worry about what the neighbors are thinking and saying. They don't realize until too late that their spouses are becoming alcoholics, for they have never learned the warning symptoms of alcoholism. In fact, many of them aren't even aware that alcoholism *is* an illness; they simply don't understand why their mates can't stop drinking. These people have mixed emotions and feelings toward the alcoholic and his illness.

To many of these persons—the families and friends of alcoholics—Al-Anon has meant a new and better way of life. It offers them the realization that others share their problems. No longer do they have the feeling of being alone, the feeling that nobody knows the troubles they bear, the feeling that nobody cares.

Al-Anon gives them the opportunity to modify their attitudes. Feelings of shame, possessiveness, maudlin sympathy, self-pity, resentment and pride are put aside, and an attempt is made to face their problems squarely with an open mind. The acceptance of spiritual values such as humility, patience, and honesty gradually leads to courage in meeting old situations with new confidence and new situations with calmness.

Besides attempting to modify their attitudes, members of Al-Anon study the phenomenon of alcohol and its effects on the body and the mind. They gain a better understanding of the alcoholic and his problems by discussing the concept of alcoholism as an illness, its symptomatology, and its causes.

The Al-Anon member learns that by developing new and more positive attitudes he can better help himself and the alcoholic, too. Attendance by family members at Al-Anon meetings often precedes changes on the part of the problem drinker who perhaps previously would not seek help.

Al-Anon is the answer for parents, husbands, wives, and friends of alcoholics who desire to learn more about alcoholism and the problems which it presents to the alcoholic and to those persons near to him.

As parents really never outgrow their sense of responsibility for the actions of their children, no matter what age they may be, many of them find solace in Al-Anon if their child has gone astray.

Children of alcoholics, too, can benefit, as through their parents they may learn about the illness of alcoholism and how it has affected family relationships.

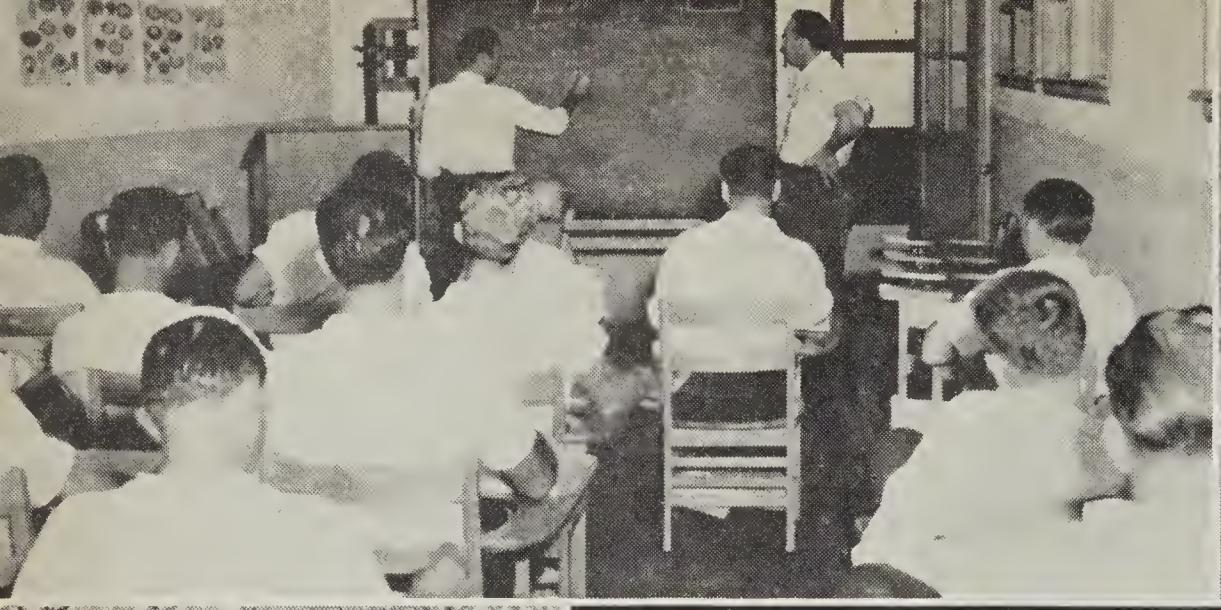
Many an alcoholic spouse has given in when his "better half" has turned to Al-Anon. A member of Alcoholics Anonymous has remarked that he knew he was a "dead duck" when his wife started attending Al-Anon meetings. Of course, this is not always the case, but if it happens in just a few instances, certainly it is worthwhile.

There is hope, dignity and serenity to be found, to be re-discovered through Al-Anon. Courage with which to face each day is renewed and a new sense of well-being is born.

While Al-Anon is entirely separate from Alcoholics Anonymous, the two organizations are closely allied and work together whenever possible. Both stress the anonymity of members. Al-Anon members are familiar with the Twelve Steps of AA, their twenty-four-hour program (One Day at a Time) and their lovely Serenity Prayer: "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

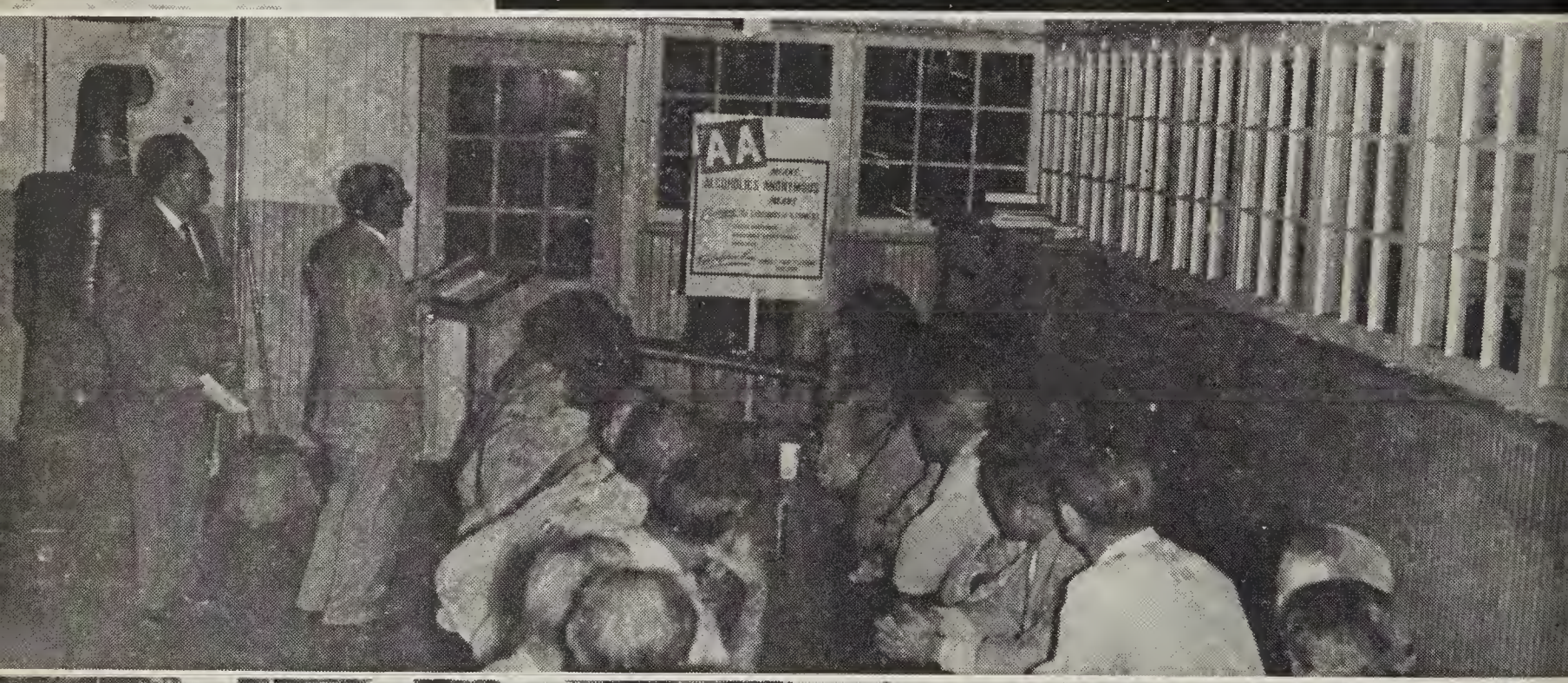
Al-Anon's headquarters are located in New York and information concerning the group's structure and method of organization may be secured upon request from Post Office Box 782, Madison Square Station, New York 10, N. Y. Al-Anon has no fees or dues. A group may be developed to conform with needs of specific localities.

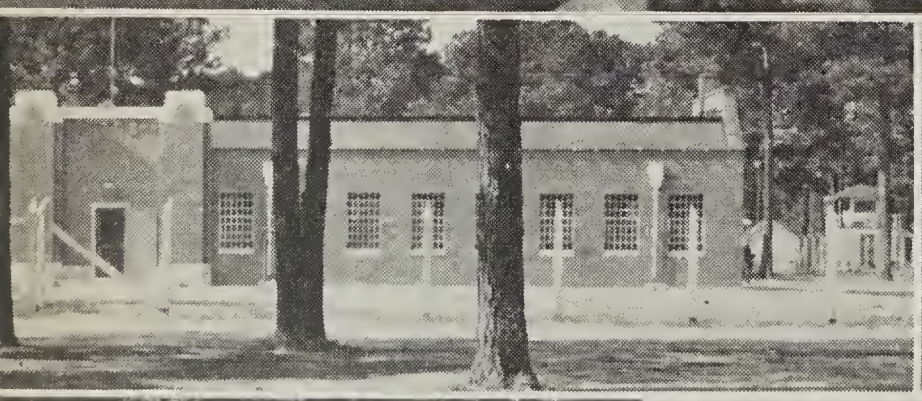
Until recently, society has deemed the alcoholic an outcast, and has treated him with such revulsion that he has either been hidden, protected, or "kicked out." The stigma remains with us to a certain extent. But we are making progress. Through education we have learned the early warning symptoms of alcoholism and, with intelligence, we have taken steps to curb this developing illness and to help those affected by it. But there is still much to be done; there is still a long way to go. We do not know all the answers, but certainly Al-Anon is one.

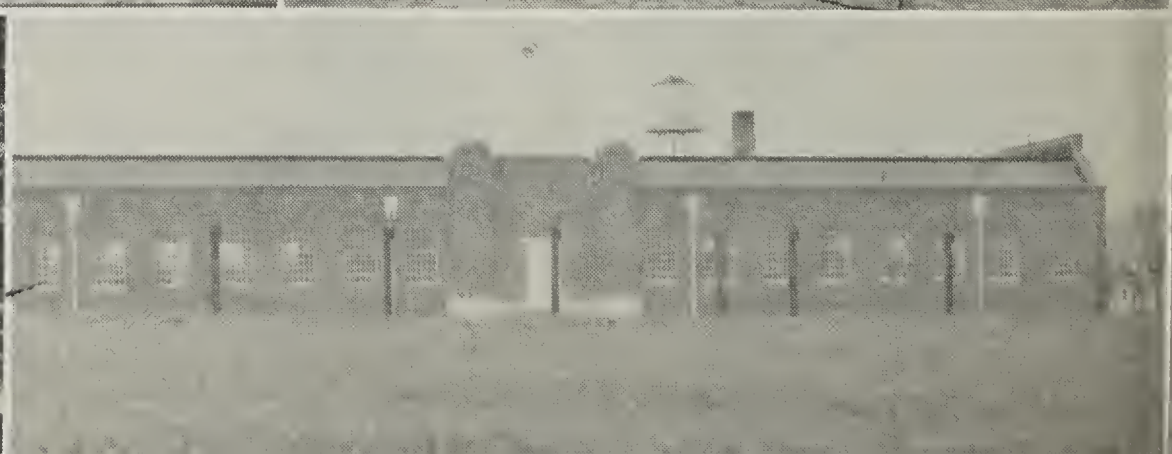


ALCOHOLIC REHABILITATION IN THE N. C. PRISON DEPARTMENT

BY DAVID GODFREY







The supervisor of alcoholic rehabilitation in the N. C. Prison Department discusses the progress and future plans of the program.

The North Carolina Prison Department is obtaining substantial and encouraging results from its rehabilitation program for alcoholic inmates which was initiated in September of 1957.

The rehabilitation program includes weekly Alcoholics Anonymous meetings, now being conducted in seventeen prison units, which are supplemented by educational programs conducted by professional personnel. Participation in the program by the inmates is on a strictly voluntary basis.

The AA meetings are conducted by "outside" members who have a dedicated desire to help, many of whom once underwent the hardships now being experienced by the alcoholic inmates.

The North Carolina Alcoholic Rehabilitation Program and the Raleigh, Durham, Greensboro, Charlotte, and Asheville local alcoholism programs have been of tremendous assistance in developing the educational program which consists of lectures, films, and discussion periods on alcohol, alcoholism, and problems of living and adjustment in a free society. Through their cooperation, the support and participation of local professional personnel such as psychiatrists, psychologists, physicians, social workers, and health educators has been enlisted.

There is no question that alcoholic rehabilitation in the prison system is a grave, as well as, sizeable problem. Of the 18,000 persons committed during the fiscal year ending June, 1960, forty percent or 7,200 were incarcerated as a direct result of the excessive use of alcohol. This group is composed of short-term prisoners who were convicted of public drunkenness, drunk or disorderly conduct, and driving drunk. Another thirty-five percent or 6,300 long-term prisoners who were convicted of non-support, murder, assault, involuntary manslaughter, etc. have a history of excessive drinking in their backgrounds. The cost to the taxpayers of keeping these men and women in prison, considering the average length of stay and welfare payments for maintaining their families, is approximately fifteen million dollars per year.

The alcoholic rehabilitation program has been one contributing factor to an improvement in this picture. For the first time in history, the prison population is on the decline. Just as important is the fact that many of the alcoholic inmates who attend the prison meetings are known to be leading sober and constructive lives since release.

A survey to determine the effectiveness of the alcoholic rehabilitation program during the period, September 1, 1957 through December 31, 1960, has just been completed. It was accomplished by a recapitulation of the records which are maintained on the inmates who attended the AA meetings and who were released during this period. Information required to maintain the records is obtained through verbal and written communication with outside AA members, parole officers, and from the Consolidated Records Section of the prison department.

The survey revealed that the alcoholic inmates who attended AA meetings regularly during their con-

finement and were subsequently released fell into two categories termed, for purposes of this article, "successes" and "failures."

The success group includes a total of 821 ex-inmates who have *not* returned to prison. Many of them are definitely known to have remained sober and are active in outside AA groups. The period of freedom and sobriety for this group ranges from three to 36 months.

The failure group includes a total of 306 ex-inmates who resumed drinking after their release and all of them have been returned to prison, mainly for drunkenness. Some of them did manage to stay out of prison for as long as 12 months during the period of this survey.

All this, with the mobilization of outside resources on a voluntary basis, has been accomplished at a cost to the prison system of less than $7,000 for the salary and travel expenses of one individual. It is noteworthy that, in the past three years, more than 350 outside AA members and professional people have traveled more than 300,000 miles on their own time and at their own expense to conduct and participate in the rehabilitation program.

Greatest Success

Our greatest success has been with the individuals who are incarcerated for as much as ninety days or longer, who have a measure of continual ties with their family, religious, and educational backgrounds, and who normally live in regularly established households and have held forms of stable employment. With these inmates, the positive aspects of no longer drinking are supported by the incentive of regaining a desirable way of life wherein they are regularly employed and enjoying normal domestic relationships. These are the inmates with sufficient social assets that they can draw on the activities and the companionship of AA to help get them over periods of crisis in the process of their recovery. There is a constant pull and desire on the part of these inmates to rise back up to their normal standard of living.

The least amount of success has been with the chronic drunkenness offenders whose family, educational, and employment backgrounds are fragmentary. Many of these have spent years in social isolation bereft of normal experiences or personal interactions and they often lack the basic techniques for getting along with other people. The rehabilitation of such inmates is complicated by the fact that even if they learned to live without alcohol, their lives have no meaningful purpose. Furthermore, the thought of adjusting to life in normal society suggests many strange and frightening experiences to them made all the more painful if they must be without the anxiety depressing effects of alcohol. Indeed, there usually seems to be far greater incentive for them to escape from the realities of marginal existence.

Many chronic drunkenness offenders whom I have interviewed appear to feel that they do not have a drinking problem. Many of them recognize, quite frankly, that alcohol is providing them with a means of going on from day to day and facing life on the outside. Some have frankly stated that they desire no change in their drinking practices. Sobriety for these men is frightening and full of insecurity and anxiety.

The basic problem for a considerable number of them is one of dependency rather than alcohol. Incarceration appears to be a welcome relief to them since the basic necessities such as food, clothing, shelter, and medical care are provided. Their daily routine is also planned and demands on their individual initiative

are at a minimum.

It is believed that any program for the successful rehabilitation of chronic drunkenness offenders must aim to meet their dependency needs as a prerequisite to any change in their drinking patterns. Some cities have partially met the dependency need through the operation of half-way houses or similar facilities. Briefly, a half-way house is a public supported facility which is equipped to house, feed, and clothe indigent and homeless men for a certain length of time on a no-charge basis, at first. AA meetings are held regularly and the men are encouraged to obtain regular jobs and become fully self-supporting. They are then "eased back into society."

Tentative plans are being made to establish half-way-house type facilities in Charlotte and Winston-Salem, N. C., and consideration is being given to this idea by representative citizens from several other of the larger cities throughout the state.

The Prison Department is proceeding with definite plans to build a special Alcoholic Rehabilitation Prison Unit with a capacity of 400 men. It will be built in or near the Raleigh-Durham-Chapel Hill triangle area in order to utilize available professional personnel such as psychiatrists, psychologists, sociologists, and psychiatric social workers. Tentative plans are to pattern the program after the treatment program of the state's Alcoholic Rehabilitation Center at Butner plus making full use of the AA program.

It is fully realized that a special and modern approach is required to rehabilitate the drunkenness offender. Confinement to jails and work programs, religious exhortation, physical reconditioning, enforced abstinence, and job finding have all been attempted. By and large they all have failed. Furthermore, according to our best knowledge today, they will continue to fail.

More Than Dollars

As outlined previously, we have already effected a tremendous saving to the taxpayers; however, the benefit cannot be measured only in dollars. There is no guide to measure the return of self-respect, the rebuilding of broken homes and families, and the ability and desire to work steadily. There is no way to estimate the number of cases where the seed of hope has been planted, nor foresee when the seed will begin to grow and bear results.

Present plans anticipate the continued expansion of the AA program into additional prison units as rapidly as practical since the special alcoholic rehabilitation prison unit will not come into existence until the latter part of 1963.

Never in the history of the State of North Carolina has the State risked so little and gained so much as it has from the alcoholic rehabilitation program in the prison system.

A CONTRIBUTING FACTOR

Alcoholism is not a primary cause of criminal behavior, because there are many alcoholics who drink but never commit any crimes. There are, however, persons who commit crimes only when they are under the influence of alcohol. In these cases, alcohol is considered a contributing factor to criminal behavior and it is estimated that in about 40 percent of the men in prison, alcohol helped to reduce their censoring and controlling mechanisms, making it possible for them to act antisocially.

—Richard A. McGee, Director of Correction, California

The half-way house bridges the gap between corrective institutions and the community. While providing the protective and supportive features of family life, it helps the individual find his rightful place in society.

BY EDWARD
ALCOHOLISM RESEARCH ANALYST,
DAVID R
PROGRAM DIRECTOR, COLLEGE VOLUN

IN the everyday language of the lay public and most of the professional public, the alcoholic label is assigned somewhat loosely to all persons who overindulge habitually. Loose application of the alcoholic label is not too surprising, for even the experts are still struggling for a clear and utilitarian definition. Until a more completely satisfactory definition is available, for purposes of this discussion on half-way houses, we must be content to simply denote descriptively the population generally serviced by the half-way house.

The kinds of problem drinkers that are found in half-way houses include mainly inveterate excessive drinkers frequently referred to as Skid Row bums or homeless men, and "addicted" drinkers of the "lost weekend" variety who have reached the depths of personal, social, and physical degradation. Common to these two types of problem drinkers is the fact that they are down and out and that they chronically offend against the law in the form of public drunkenness. To the police, the courts, the probation and prison officers, they are commonly known as chronic drunkenness offenders.

Although the chronic drunkenness offender comprises an estimated 10 percent of the total national alcoholism problem, his behavior or perhaps misbehavior is not readily seen, or, if seen, is not seriously acknowledged by the general public. The homeless man or the staggering drunk who approaches us for a dime in the city's business districts is quickly brushed off and forgotten, and the days when it was fashionable to visit Skid Row are long since past. In talks to the citizenry and even to professional workers, we are not unfamiliar with the surprise and shock our listeners experience when informed that Massachusetts has approximately 65,000 arrests for drunkenness each year, and that exclusive of traffic violations, drunkenness constitutes more than 50 percent of all arrests in Massachusetts.

Notwithstanding the general public's lack of recognition of the drunkenness offender problem, the police,

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the courts, and the prisons are all too well aware of the problem, for it demands an enormous dissipation of their services. Add to this the economic factor and we can then better weigh the tremendous social cost involved. For example, in a recent study, it was found that in Massachusetts the chronic drunkenness offender is likely to have the dubious distinction of being arrested an average of five times a year. In a lifetime he has probably accumulated about 50 arrests. Although these kinds of arrest figures will vary somewhat from state to state, arrest incidence for drunkenness is always high enough to say with fairness that no state is free of the problem.

Lest the wrong impression be created, we hasten to add that the nation's alcoholism problem is much larger and in many ways even more

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taxing than the serious chronic drunkenness offender problem. Also, we do not mean to imply that the chronic drunkenness problem is so immense that there is no solution to it. As a matter of fact, in the last decade the application of half-way house rehabilitation for this type of man injects into the picture the hope that the cause is not lost.

Just as there are differences between the chronic drunkenness offender and other types of problem drinkers, there are differences between persons within the ranks of the chronic drunkenness offender. Individuals vary in the manner in which they arrive on Skid Row, how they adjust to the Skid Row life, their attitudes toward it, and the degree of anxiety felt in belonging to this subculture. Recognizing that differences do exist, it will suffice here to point out some basic similarities of these offenders.

The drunkenness offender fences off closeness with other human beings, and therefore often lacks stable friendships and family relationships. His employment is irregular. He is oriented to the present with tomorrow being meaningless. Social mobility is decelerating, and he is apathetic about society's laws. His main loyalty seems to be to alcohol and to

his drinking fellows with whom he feels a pseudo-camaraderie.

All of these attributes, from a rehabilitation point of view, have led the general and professional community to consider the chronic drunkenness offender as hopeless and unreachable, or at best a very difficult matter. This feeling or attitude contrasts considerably with that held toward problem drinkers attending clinics and Alcoholics Anonymous groups. With the introduction of the relatively new half-way house rehabilitation method, there exists now a bit more optimism, for experience has demonstrated that this reasonable and comparatively inexpensive approach has greater success than any previously tried.

Aims And Features

The half-way house, as the name implies, is a facility which bridges the gap between penal and other large institutions and the community. It makes the assumption that certain individuals can best be rehabilitated if their return to the community is gradual rather than abrupt. Its aim, starting with sobriety, is gradually to introduce the men to jobs, independence, and respectability in the community. In the process of achieving this aim, the men also gain or regain a sense of pride, self-respect and a will to live.

The general organizational, staffing, and programming patterns of halfway houses vary. There are, however, several central features on which practically all half-way houses are in substantial agreement.

One main point of agreement is that the number of individuals served is kept relatively small. Having a small number of patients at any one time in the half-way house enables the men to receive a greater amount of individual attention for their particular needs, and allows for man-to-man management. The small number of men combined with the group-living arrangements develop for the majority a sense of group belonging and participation which the offender desperately needs before he can associate normally in the large community.

A second self-evident point of agreement is that the members are expected to stay sober. If the individual offender is plunged directly into the community from the large institution, or is treated in an outpatient situation, a protective environment is generally lacking for him. Unable to receive gratification from the middle-class environment which will not accept him for what he is, he is forced to return for support to the Skid Row environment and the drinking that goes with it. On the other hand, under the protection of an environment of people like himself and sympathetic workers, he can receive much more support and learn to survive without drinking.

The third common factor in all half-way houses is that the men are expected sooner or later to seek employment. Employment lays the groundwork for half-way house residents to be self-supporting instead of dependent on the community, and thereby creates a sense of responsibility. It also builds up their self-esteem and self-respect, hopefully and gradually giving them a feeling of community acceptance.

Lastly, a crucial aspect of the half-way house is the therapeutic environment. In general, this is an attempt to create a warm and responsive atmosphere or emotional climate in which the alcoholic is given an opportunity gradually to learn how to live a conventional and more constructive life. It is an attempt to use everything in the total environment —personnel, facilities and relationships—to accomplish this goal. It is

a healthy environment with which the individual can identify.

In general, then, the half-way house environment can be characterized as a group-living experience which reconstitutes the protective and supportive elements of a good family, while encouraging and providing opportunities for independent growth. It should be remembered that the alcoholics and inveterate excessive drinkers have suffered a breakdown in their ability to get along with other people. They tend to be immature individuals whose main problem is controlling drinking behavior that is disapproved by others. In the context of the therapeutic milieu of the half-way house, they are helped to substitute their troublesome patterns of behavior with more appropriate modes of coping with the environment.

Half-Way House Survey

Information on how the previously described aims and features are carried out organizationally and procedurally was obtained through a "Half-Way House Survey" conducted in 1958 under the auspices of the Massachusetts Division of Alcoholism. A questionnaire was mailed to all the 49 states, Washington, D. C., all United States territories, and all Canadian provinces. Ninety percent replied. Out of all the responses, there were 30 institutions in 17 states, Washington, D. C., and one Canadian province which seemed to meet the required criteria for a half-way house. These 30 are felt to give a fair and representative picture of organizational and procedural patterns.

There is a good deal of variety in the operations of the 30 half-way houses which are located in many different kinds of houses and buildings. Two-thirds, officially and financially, are under public auspices. They are administered by a board of directors and/or an advisory board, with the former being the predominant mode of administration. A little better than half of the group have some affiliation with a hospital or agency. One-third are connected unofficially with Alcoholics Anonymous through their membership and staff.

Sixteen of the 30 respondents supplied figures on the cost of the programs. The annual cost ranged from $5,000 to $80,000, but, on the average, it cost $36,000 to run a half-way house. It should be understood that initial costs, involving permanent capital investments, are higher than continuing costs. As the program continues, and as more and more clients are able to pay weekly sums, the programs move in the direction of self-support. Even if the latter were not the case, the operation of these programs is less expensive than the municipality's expenditures for police, court, jail, and hospital treatment costs otherwise incurred by these chronic offenders.

Twenty respondents supplied information on the estimated rate of rehabilitation. The rehabilitation figures, which were based on either subjective estimates or actual figures kept over a period of time, varied considerably. The average for the entire group was 35 per cent. Since the men involved in these half-way houses have generally been given up as hopeless and unreachable, it is strongly felt that this rate of success is quite impressive. Certainly it is considerably beyond the results of ineffectual jailing and confinement.

The therapeutic program varies with each half-way house and includes the following: (1) group therapy, individual psychotherapy, social work, and other kinds of personal counseling; (2) religious and vocational counseling; (3) Alcoholics

Anonymous meetings; (4) the use of "Antabuse." Only 10 percent of the surveyed half-way houses limited their programs to only one of the aforementioned categories; 90 percent had programs which included two or more of these categories.

The clients served are required to pay fees by 81 percent of the half-way houses. The fees are paid on a daily or weekly basis and on a weekly basis they range from $7 to $110. The $110 fee, applying in only two cases, is atypical, for the average fee charged by the institutions is $15 a week. These fees are usually waived during the individual's initial weeks at the institution, and they begin when he obtains a job. Every half-way house in the survey either encourages or requires its clients to obtain employment. This is considered an extremely important part of the program since steady employment is a step toward respectability and one of the principal keys to rehabilitation, while at the same time it ensures partial financial support of the program by the members.

Model Half-Way House

The surveyed half-way houses also have differences in staffing patterns, admission, discharge, and readmission policies, bed capacity, length of stay, residence facilities, and the extent of patient government. Nonetheless, even with these differences in approach, all of the half-way houses have had some success. We would like to select the best features from this survey to fabricate a composite picture of what, to the writers, would be a model half-way house.

The location of the facility deserves careful consideration. It should be in a central urban area where there is low cost public transportation, and near centers of occupation, particularly unskilled and semiskilled employment. It should also be in a city near the homes, or former homes and families of the men. It should be located in a respectable residential neighborhood whose social status is neither too high nor too low, and not close to Skid Row habitats or concentrations of bars. It is also desirable to choose a central urban location so that qualified staff, including part-time, consultive, volunteer, and other unpaid personnel, may be obtained and can travel with relative ease to the treatment center. This would also enable the half-way house to use existing educational, research, and training facilities that are available in such areas.

Physical Characteristics

As for physical characteristics, the half-way house should be a "family" type residence with furnishings that are adequate, though simple, and furniture that has firm rather than stylish construction. There should be space for offices, meetings, recreation, a lounge for quiet reading and relaxation, dining facilities, and sleeping accommodations. Regarding sleeping accommodations, the Belmont Rehabilitation Center in Worcester, Massachusetts has worked out an interesting and successful sytem. The men live closely at first in dormitory style. As self-improvement progresses, the men are advanced to accommodations for three. And finally, when a man is considerably improved he is "graduated" to a single room. Each step in this ladder-like progression provides more comfort, greater convenience, and added prestige through a concrete recognition of his progress. But whether or not some system is used for assigning different accommodations within the plant, it would seem that the model half-way house should have different types of arrangements and, above all, emphasis should be

on creating a home and club-like atmosphere.

The bed capacity should be limited to 30. Admission and eligibility requirements should be decided by the administrator and staff with consideration in particular of age, sex, and sobriety. The residents must agree to abide by some general rules and regulations such as curfews, schedules, house chores, program attendance and the like, which should be designed to maximize chances for recovery. Fees should be waived initially, but when employment is obtained the resident should pay a reasonable fee of $15 weekly.

On entering the program of the model half-way house each individual should undergo a three-day orientation phase, beginning with an initial interview and ending with a commencement of the regimen of daily activities. In this orientation period the man would receive a physical examination and would be introduced to procedures and rules, the program and methods, the philosophy and its bearers. At this time he would learn what he can expect from the staff, fellow residents, and the half-way house in general, and what is expected of him. At the same time the staff would formulate suitable plans for his future participation in the program.

The program itself should provide for participation in some kind of counseling or psychotherapy, either individually or in a group. An AA group should be formed for residents only, using their own and outside speakers, and they occasionally should attend outside meetings. The men would also participate in the frequent group meetings concerned with daily problems and policies related to government and management of the center. Using principles of self-government, the men themselves would exercise responsible authority in enforcing the rules and policies which govern the behavior of residents. Each man should be helped to find employment as soon as possible after completing orientation, and should receive both casework and vocational counseling in this regard as required. Arrangements should be made for clergy of various denominations to be available for religious counseling and spiritual help at the request of the men.

The Staff

The staff for carrying out the program should include a top-level professional with training in the social or behavioral sciences who would be the director. He should have some experience in administration, supervision, institutions work, treatment, and research. An assistant director with similar qualifications, although of less experience, would aid the director. There also should be a resident supervisor, perhaps a recovered alcoholic who has clearly demonstrated a capacity to assume responsibility. The latter individual is a key figure, for he must see that the affairs of the institution are run smoothly, and be available to meet the needs of the men in times of stress. The director, assistant director, and resident supervisor would be full-time. In addition there would be on the part-time consulting staff one psychiatrist, two social workers, one psychologist, and one researcher. These part-time consultants would do diagnostic work, and would plan and conduct treatment. All personnel must be equipped with warmth, maturity, and understanding.

Emphasis in the last stages of the program should be placed on easing the member back into a less protected situation in the community.

(Continued on page 31)

Psychotherapy of Alcoholism

• *The role of the therapist has changed from that of a detached listener to a warm, understanding individual with flexible therapeutic principles.*

CLASSICAL psychotherapy has generally endorsed a neutral, detached role for the therapist. He was supposed to listen more than he talked and to awaken in the patient the dormant strength for self-discipline, rather than impose discipline from outside. Achievement of his goals depended largely on his ability to maintain a dispassionate objectivity in the relationship. He must not scold, threaten, bargain, implore, congratulate, punish, direct or otherwise demonstrate any signs of personal emotional involvement.

But as with all dynamic schools of thought, the original concepts have undergone modification. In some quarters it is considered important for the therapist to project himself as warm, sympathetic, interested. He need not strive to seem an inanimate symbol of justice. Most important of all, his therapeutic principles should be flexible enough to meet the needs of different patients. With some, an objective detachment will merely represent disinterest or rejection. In such cases, prolongation of treatment will be the only outstanding result.

"The psychotherapist who is prepared to deal with the alcoholic must be prepared to be a pioneer in his approach to each case," writes M. E. Chafetz after several years of work with problem drinkers at the Massachusetts General Hospital. The dependency needs of some may be so overwhelming that hospitalization provides the best solution while these antecedent problems are tackled. With others, the same end can be achieved by the simple act of prescribing a drug. But mainly the physician should be ready to play a more active role than in the past. Doing tangible things for the patient is no longer taboo.

Chafetz retains a minimum of theoretical dogmas. In handling the alcoholic, the therapist must first assess the personality traits of the particular case, then bend treatment methods to fit. Relatively silent detachment is one of the first ortho-

dox principles to be discarded. A positive, warm relationship must be established as rapidly as possible. Without this firm bond between therapist and alcoholic, no approach will succeed, in Chafetz' opinion. It may take a few interviews or several years to develop but it cannot be bypassed. "When it appears to be firm the patient will test it again and again, and even when the tests are passed the bond will be tested further. To ensure such a bond the patient must be offered help again and again, no matter how often he fails and resorts to alcohol."

This one unvarying principle governing the treatment of addictive drinkers grows out of the observation that they do share one experience in common—namely, early emotional deprivation with respect to a parent, either tangible loss through death or absence, or symbolic loss through rejection. The effect of this experience is to hinder the process of emotional maturation, the steps from dependence to independence. Life for this person becomes an unconscious quest for reunion with the lost parent. And since the quest is doomed to failure, a substitute "parent" must be found —someone protective, loving, all-giving. Again and again the wish is frustrated. For many of these deprived individuals, alcohol turns out to be the most satisfying way of handling their feelings of emptiness. It warms, it comforts, it dissolves the depression, it eases the fear. The hungry self can be endlessly indulged, the sense of loss can be assuaged. Small wonder, then, that the addict finds it difficult to give up his most valued possession. The therapist too has difficulties, standing as he does in the position of one who takes alcohol away. It is not surprising that the classical method of disinterested detachment has not met with success.

If the therapist can become the substitute parent for a time—protec-

tive, understanding, accepting, regardless of how the patient is behaving—alcohol may not be needed quite so desperately. Some of the addict's deepest longings will be fulfilled for the first time. He can afford to risk sobriety, if only as an experiment. In most cases, however, the relationship will not run smoothly. Basically suspicious of all human beings, because of his disappointment early in life, the alcoholic will not immediately trust these demonstrations of warm acceptance. He cannot help feeling that there must be a catch in it somewhere. Unconsciously he anticipates rejection—it is only a matter of time.

In the period that follows, the therapist can expect to be tested in an endless variety of ways. If his patience comes to an end, probably treatment will also. Rebellion, relapses, must be met with an attitude of tolerant acceptance but tempered with consistent firmness, for being overly nice or permissive will damage the therapeutic relationship as much as showing open hostility. "The therapist who must dominate his patients to compensate for his own insecurity, and the one whose motivation is to be loved by all, will rarely deal successfully with the addictive alcoholic." When the patient comes to feel that he can safely lay aside his distrustfulness, then it becomes possible to begin the process of weaning. Little by little the therapist now must encourage his patient to make decisions for himself. By imperceptible steps he is encouraged to face the reality problems. Gradually he assumes more responsibility for dealing with them. The protective parent now must curb his tendency to perpetuate the dependency relationship, and the alcoholic must experience the rewards of growing up.

During this critical stage, renewed anxiety about rejection will almost certainly appear. Carelessness on the therapist's part, such as being late for appointments, canceling without sufficient notice, making promises and not keeping them, may evoke a storm of resentment, set back the progress of therapy, renew the danger of relapse. The therapist must take particular pains during the weaning phase to avoid all the pitfalls which can be interpreted as signs of rejection.

Just how far the patient can go in treatment is a question of individual potential. The goals must be set realistically. For some, the limit is a supportive relationship with help in controlling drinking; that is all they can tolerate. Others may be capable of enormous growth through intensive uncovering techniques. In formulating the course of therapy, Chafetz advises the goals should be based on a team evaluation of the patient's make-up; many hours will need to be spent amending or confirming the original formulation.

Termination of treatment is another difficult time for the addict. The substitute parent has been found and then lost. Although ideally the patient has outgrown his need to be dependent, in practice the resolution of these problems is less than perfect. Here Alcoholics Anonymous can be immensely helpful to certain individuals. Because it is an uncritical, accepting group, an action or "doing" group, it can serve a supportive function indefinitely. In a symbolic sense, the fellowship replaces the lost mother-figure. It is protective, it is benevolent, it is giving in many important ways. The A. A. member will never have to fear being rejected.

ALCOHOLISM and the FAMILY

BY HERMAN E. KRIMMEL
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● *The family can help the alcoholic through acceptance, understanding.*

THE alcoholic is a social liability in many areas—in industry, in the professions, on the highway, in neighborhood activities. The most damaging impact, however, is on the family because they are exposed to the emotional and economic effects of the illness every day of their lives.

Usually, the initial reaction of the family is to deny the drinking difficulties. Spouses and children resolutely close their eyes to even the most persistent evidence that social drinking is becoming problem drinking. This may be the result of their inability to believe it has happened to them. It is more likely their reluctance to accept the stigma still so tenaciously attached to alcoholism. Neighbors gossip without understanding and children's friends are cruel in their taunting.

This denial unintentionally allies the members of the family in a conspiracy with the alcoholic, because his own need to deny is so overwhelming. The difference is that in his frantic search for reasons to drink he masters the skill of shifting the blame and finds those reasons in what he regards as intolerable faults of the family. He justifies his drinking because his wife is an impossible shrew, because his children are incorrigible and, in general, because those loved ones for whom he has done so much seem determined to make his life miserable. The real reason, of course, probably lies in his inability to accept the responsibilities of family life and each additional burden may provide renewed impetus to his drinking. The onset of excessive drinking in some men, for example, can be traced to the birth of the first child. Despite vigorous protestations of paternal pride, his reactions are panic and escape to the bottle.

Bewildered members of the family, especially wives, frequently play right into the alcoholic's hands by accepting the burden of guilt. A recurrent question heard by anyone working with the spouses of problem drinkers is the plaintive, "Whatever did I do to make him this way?" Moreover, a wife can be required to lie and deceive in ways that add to her shame. She is repeatedly called upon to make excuses to friends and to phone the boss to report that her

hungover husband has a severe cold or upset stomach and will not be able to get to the office.

Inevitably, severe illness eventually shatters the wall of silence and pretense. The economic assets of the family may be dissipated with the loss of one job after another. Tensions mount daily. When finally awakened to the real plight, the family tends to reorganize to cope with the situation. If the alcoholic is the father, he may be stripped of his usual functions and relegated to the status of a naughty child. He no longer participates as parent and husband.

One disastrous consequence in the family relationship is the sexual turmoil. The impotence that often accompanies heavy drinking, plus rejection by his wife, bitterly emphasizes the patient's self-doubts. He may drink as a defense against sexual frustration which only makes him less attractive as a partner. In this situation it becomes almost impossible for the man to blame himself, so he turns on his wife and accuses her of infidelity.

There has been considerable speculation about the neurotic reasons for women marrying alcoholics and some researchers have suggested darkly that these women unconsciously select their mates to meet their own needs. This may or may not be so. In any event, no one has ever suggested that children choose, consciously or unconsciously, to be born to an alcoholic parent, and it is the children who are most susceptible to damage. Incidentally, it is estimated that approximately two-thirds of the married alcoholics have children.

It is difficult for a child to weather life in the family of an alcoholic without some distortion of values. At best, he may see his father's role nullified and usurped by the mother. At worst, he may witness or even be the victim of verbal and physical brutality. He may see his father beat his mother for reasons he cannot comprehend. He may see or hear the crudest manifestations of sexuality and his own attitudes may be shaped by this. One of the patients at the Center, a respectable and placid man when sober, totally wrecked his home in a drunken rage. The children cringed and watched with horror. Another occasionally used his wife as a practice target for knife throwing and joked about it to the children.

Stability is almost foreign to the family of an alcoholic. Children are constantly faced with unpredictable parental attitudes and the alcoholic parent is inclined to swing between behavior that is gross and maudlin, between senseless generosity and equally unreasonable harshness. The broken promises and disappointments can be almost unendurable.

For children there are divided loyalties and, all too often, they are used as weapons by warring parents. Moreover, they feel rejected by the alcoholic parent because "if he really loved me, he would stop drinking."

We have stressed the alcoholic father, but it can be just as difficult to have an alcoholic mother. Dr. Ruth Fox thinks it is even more so because "it is often possible for the mother to shield the children from the full impact of the situation" if the father is ill. "With an alcoholic mother this is rarely if ever the case. Because of the closeness of the children to the mother, they are apt to suffer irreparable damage."

We still know comparatively little about the specific effects of alcoholic parents on children or about the duration of these effects. We do know enough, however, to warrant intensive and extensive research.

He quit drinking and expected his life to be a garden of roses but soon found out that reconstructing home life is a life-time job.

HOME RECONSTRUCTION — A LIFE-TIME JOB

BY WILLIAM A. K.

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ONE subject we alcoholics often leave on the side and hardly ever bring out into the open is the problem of reconstruction in the home. It is, of course, as we all know, a touchy subject. No two homes are alike and each man has to find an individualized solution.

When I came to Alcoholics Anonymous for help, I had been drinking heavily for over twenty years, that is, for the whole span of my married life. Except for my brief periods of sobriety my wife had never known what it was like to live with a normal, sober husband and even then my temper, balance, and judgment were pretty shaky. Yet, she did the best she could to adjust to my abnormal habits. She accepted my hangovers, forgetfulness, and unreliability as unpleasant but constant factors of family life. I take it she must have done this out of love. Reason would have told her to cut her losses and leave me.

One often meets new members in AA who have started on the road to permanent sobriety, who are working for the first time in years, and yet they see no need for reconstruction in the home. I was one of them. I hoped for a better home life but, instead of pouring out affection, tolerance, and good humor on that starved soil and showing (not by words, but actions) an humble gratitude to my wife for having stuck with me, I looked to her to make the moves and grouched inwardly because she never came to AA meetings. I expected the shambles which I had created to become a garden of roses just because I had stopped drinking. I did not realize that my good wife was exhausted or that, in those years of neglect and abuse, I had forfeited any right to make demands of her.

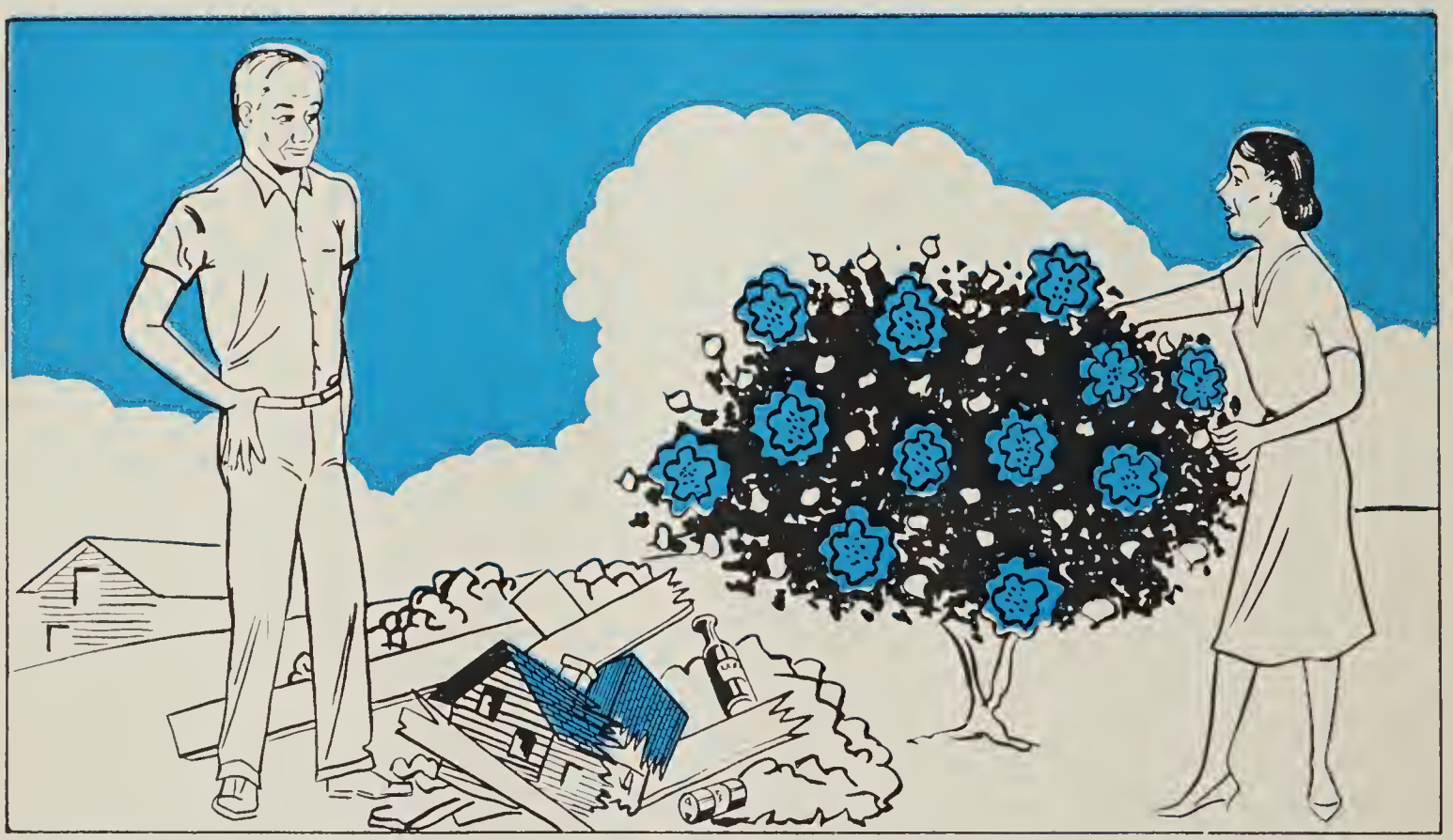
It is true, no doubt, that we did love those who were nearest to us. Alcoholism did not remove our humanity, but our expression of love was so feeble, so erratic, that it may have seemed worse than indifference to those who received it. Nor does sobriety remove this feebleness with-

out conscious effort on our part. We are often peculiarly blind to the extreme, perhaps permanent, damage we have done to our partners. Debts can be paid, apologies made, but home reconstruction is, in my opinion, a lifetime job.

How can we come to an acceptance of the need to reconstruct our home life, and so make a beginning in this direction? One way is to honestly try to assess and understand how our past behavior, of which we are so painfully aware, may have affected our partners.

blaming her for "coldness".

The worst factor was undoubtedly neglect, the complete absence of that positive help and affection and reliability which a wife has the right to expect from the man she marries. She could not consult me about domestic problems. The mere thought of making a decision drove me in panic to the bottle. She could never be sure whether I would arrive home for dinner on time or come staggering in at four o'clock in the morning. But she could be quite sure that whenever she and the children were



In my case, as the disease of alcoholism progressed, worse things began to happen. When drunk, I was violent, morose, and sometimes insanely abusive. When sober, I moped around home like a man half dead, loaded with self-pity, guilt, and resentment.

At the parties to which my wife accompanied me, my behavior was atrociously anti-social. We lost many friends. She withdrew for protection behind a stone wall of reserve. I was periodically unfaithful to her and, as usual, added insult to injury by

away, I would spend the time in constant drinking and, very likely, fill the house with people as unbalanced as myself.

My last four or five years of drinking is nightmarish to remember. It must have been an even greater nightmare for her because she had no anesthetic handy.

I remember a touching scene in an AA film where Doctor Bob expresses love and contrition to his wife and she throws her arms about his neck and bursts into tears. Touching yet, possibly, misleading.

We alcoholics are extraordinarily prone to think that a few affectionate gestures and the intention to be a "good boy" are adequate compensation for years of neglect and intensely selfish living.

"But alcoholism is a disease," I seem to hear a small voice say, my own younger self, perhaps. It helps, of course, if the non-alcoholic partner recognizes this and makes due allowances. But who are we to make demands? The mangled victim of a motor accident does not consider much whether the man behind the wheel is a criminal, a fool, or just sick. The "musts" only apply to ourselves. Some say there are no musts in AA. No, not for *other* people, but I profoundly believe that to live as a normal adult I must now accept the consequences of my actions, including those which I perpetrated when drunk.

My beginning toward reconstruction of family life is a conviction that my wife's staying with me those bad years is a miracle and a realization that nothing I am able to do for her now can be more than a token of reparation.

It is plain, however, that a newly sober man may find it very difficult to cope with a relationship he has so badly fouled up in the past. Perhaps it is presumptuous of me to express myself this way after only two and one-half years or, to be more exact, 876 days (a day at a time) of sobriety with only the first steps toward home reconstruction taken. But, fully recognizing my own inadequacy, I would still like to offer some tentative points from personal experience that may help fellow alcoholics who are "in the same boat".

1. Remember always that your partner is the injured one. Your injuries, however great, are self-inflicted. She has been injured by you.

2. After the necessary AA Twelfth Step Work and attendance at meetings, home reconstruction is a first priority. The damage is gravest here and the need for reparation most pressing.

3. Get used to being criticized. Sometimes we bully our partners by threats—"You'll get me back on the booze if you don't watch out!" This is childish and dangerous. Our sobriety does not depend on our partners, but their recovery may depend a lot on us.

4. It is not our job to take our partner's moral inventory.

5. It is not wise to expect, and never right to demand, emotional changes in our partners, like the pat on the back or the welcoming arms. She has very likely been affected just as gravely as you have been by the drinking years. In her company you are walking among cases of unexploded dynamite—the resentments and fears of a person who has been forced to live abnormally for a long time. If you pursue with affection and reliability, the chances are things will steadily improve.

6. If she goes to Al-Anon, you are lucky even though its work is designed to help her, not to make her more sympathetic with you. If she doesn't go, that is entirely her own business.

7. She may want you as a lover, or she may not. If she does not, it is best accepted without rancor in the spirit of the Serenity Prayer, though I grant this can be a very tough one to handle. She is certain to need you as a loving friend. Fortunately, AA does help us to develop the talent for friendship.

8. Other people's marriages, in or out of AA, may look perfect and yet be far from it. Don't waste time envying them. If AA marriages remain firm and grow rich, it means that someone has put an enormous amount of work into them. They don't just happen that way.

9. When we were drinking, we tended either to run amok or turn to stone. Even when we have been sober a long time, the old extreme tendencies remain. Crack jokes at home, not just with the boys. They may be corny, but she won't really mind. A gloomy, stony, rectitude or the tombstone face treatment can be even more oppressive for a marriage partner than shouting and tearing of the hair.

10. In AA circles a "slip" is a misfortune. To her it may look like the collapse of life itself. If you have one, get away from her until you sober up. Expect arguments, but don't blame the slip on her.

11. If she shows aversion to discussing AA matters, don't press her or get sore about it. She has had to put up with you as a drunk. As a loud, vocal ex-drunk, she may not like you much better. Remember those discussions—about the children, money and housing, the new dress she would like to buy—that she could never have with you when you were drinking? Give her the chance to have them now.

12. In Christian marriages the husbank makes a promise to cherish his wife. I believe this to mean, that whether she is 25 or 65, a man's wife is his sweetheart. If you think so, let her know it, and act like it as far as humanly possible. She may pretend not to like it, but it will be like water and sun on starved soil.

13. The coffeehouse blondes and the loungebar brunettes are out for good. You made an idiot of yourself with them and, what is far worse, damaged her badly. A lot of the dynamite she carries, comes from that same damage.

14. If she stuck with you, she is a jewel! You are lucky to have held on to her. Remember how lucky you are, but don't think it was your personal charm that did it. The best

women sometimes pick the worst slobs as husbands.

15. The Good Lord made marriage so that man and woman could have a try at loving one another properly. AA teaches us to love our fellow sufferers. Well, who suffered more from alcoholism than our partner? The best, hardest, and most delicate reconstruction work begins in our own home.

That is what I have to say, my fellow alcoholics. It may apply to you too, or it may not, but look at it once more, just in case it does. Remember, as we say in AA, "Easy Does It".

Psychiatrists

(Continued from page 8)

of opinion? What has experience taught? Too often the voice of the clinician is muted because all he can offer is his own experience which seems pretty feeble compared with the authoritative voice of statistics. Yet all the statistics in the world will never provide one with clinical judgment nor aid one in the practice of one's trade or profession.

In the field of alcoholism, we need more people who will report their experiences as practitioners so that gradually a body of accepted practice can slowly be acquired. The knowledge of that practice and the the ability to apply it will enable the individual to be expert in the field. Not until he has that knowledge can he be called expert, no matter how thoroughly trained he may be in the same allied field.

We can now answer the question raised previously, namely, "Why do psychiatrists fail so frequently with alcoholics?" The answer is that they fail to adopt a remedial approach and consequently are pretty much strangled as therapists. Not until they know that they are tackling a disease which must be treated for itself can they hope to be effective.

My plea, of course, is for more serious study of the illness, alcoholism. My interest is not so much in causation as in the recognition of a disease which must be treated by remedial measures. My hope is that as the focus is kept on the disease, the practice of handling the disease will receive even greater study and consideration. I believe that only in that way will the field be able to climb off the limb it now occupies and reach solid ground where it can meet its obligations with some degree of consistency.

Half-Way Houses

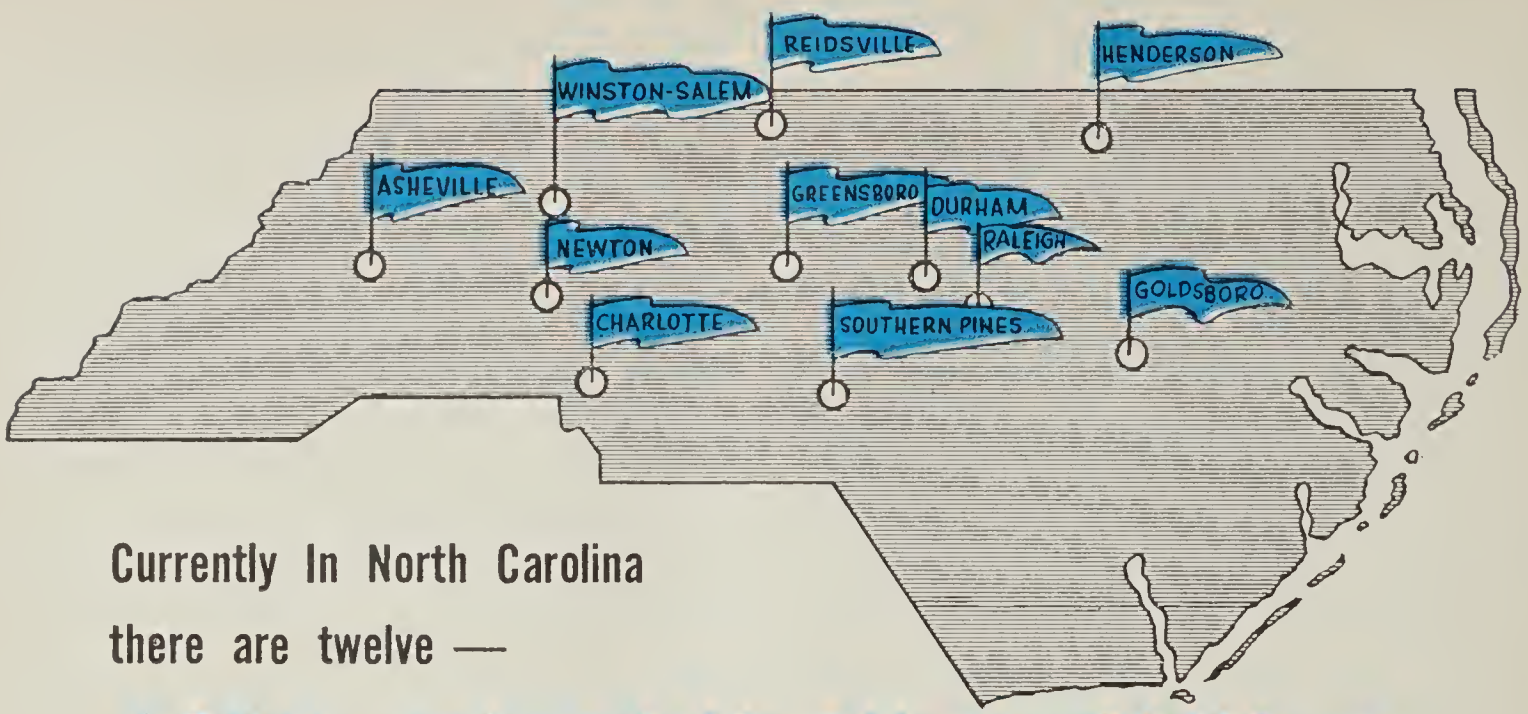
(Continued from page 21)

Length of stay in this program should be limited to 90 days. This is not an arbitrary figure, for pragmatic experiences indicate that 3 months is in many ways the optimum length of time: it is a suitable period for the majority; it avoids excessive dependency on the protective half-way house; and from the practical point of view it will allow for a reasonable amount of turnover. Readmission policies, however, should be flexible, depending on staff judgment of the individual case. And in any case, opportunities for the use of the recreational and physical facilities should be made available to successful "graduates" of the program, so that discharge does not come as a kind of weaning shock. For discharge, like orientation, is a critical period. It is a time of crisis and decision making. Every possible measure should be taken to avert failure. Efforts, which begin several weeks before discharge, should be directed at finding housing, re-establishing family, religious, and other non-Skid Row relationships, and strengthening all routes of reintegration into society.

Guideposts

These ingredients for a model half-way house are presented mainly as guideposts. Whatever the specific ingredients, however, the general goal that we recommend to any half-way house program is that it attempt to combine the best features of a relaxed home and a therapeutic milieu.

A great many problem drinkers have been and will be helped by half-way house rehabilitation. And, this is accomplished with "unreachables!"



Currently In North Carolina there are twelve —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)
Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building, Asheville
Don Dancy, Educational Director

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Excutive Director

GREENSBORO—
Educational Division, Alcoholic Board of Control, Greensboro
Worth Williams, Executive Secretary
Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320, Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center, 221 S. William Street, P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program, Division of Wake Co. Board of Alcoholic Control, 300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE—
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SALISBURY—
Educational Division, Rowan County ABC Board
Box 114, Salisbury
Peter Cooper

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098, 350 S. Ridge St.
Southern Pines
Rev. Martin Caldwell, Director

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 West 4th St., Winston-Salem
Marshall C. Abee, Executive Director

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1200 Blythe Blvd., P. O. Box 4040
CHARLOTTE, N. C.
Phone FR 5-8861
Monday through Friday

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg., 105 W. 4th St.
WINSTON-SALEM, N. C.
Phone: PArk 5-5359
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120

This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

MARCH-APRIL, 1961

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Book Reviews

Destined to Fail

Our Parents Drink Too Much

The Social Agencies' Responsibility

Mental Health is Everybody's Business

A Medical Research Man Looks at Alcoholism

Alcoholism—A Wastebasket Revolution

Letters to the Program

What's Brewing?

Editorial

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

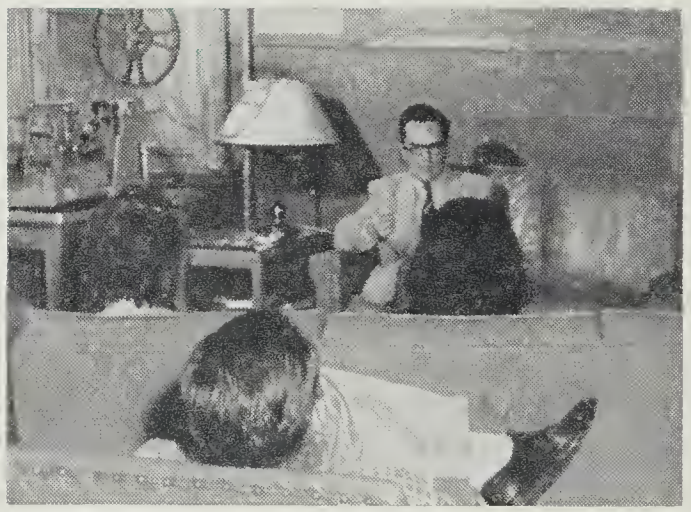
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,



compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a through medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME X NUMBER 6

MARCH-APRIL, 1961

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

LITTLE ROCK, ARKANSAS: The Arkansas Commission on Alcoholism will hold its 1961 seminar for clergymen on May 1 and 2 at the Albert Pike Hotel in Little Rock.

RALEIGH, N. C.: The Wilson County Mental Health Association received the David W. Hardee award at the annual meeting of the North Carolina Mental Health Association in Raleigh February 17. The award is given annually by the association to the "most outstanding county chapter." Among the activities for which the group was cited were: a workshop on emotional problems for teachers, participation in an area community health conference on mental health, a special project to collect needed items for patients at Cherry Hospital, and sponsoring the formation of a community program to combat alcoholism.

BAPTISTS STUDY ALCOHOL: The Methodists are not the only denomination in North Carolina making a study of alcohol and alcoholism! For the past several weeks, many Baptist Circle meetings have had as their topic of study and discussion, "Alcohol and Narcotics Education."

MINNEAPOLIS, MINNESOTA: The basis for the belief that chronic alcoholics have a lower incidence of hardening of the arteries than non-alcoholic individuals has been exploded by doctors of the University of Minnesota. Alcohol was believed to furnish some sort of protection against this widespread disease of the arteries. Since deposits of cholesterol, a fatty substance, have been implicated as influencing factors in artery disease and consequent heart attacks or strokes, the researchers set about to find out whether alcohol reduced the amount of cholesterol in the blood. The results indicated that large daily amounts of alcohol produced a small but significant increase of serum cholesterol in man. "It is clear," the doctors stated, "that alcohol cannot be considered as a cholesterol decreasing agent." The study, by doctors Francisco Grande, Lyle Hale, William Heupel and Donald Amatusio, was published in a recent issue of **Circulation Research,** scientific journal of the American Heart Association.

CHAPEL HILL, N. C.: The School of Public Health of the University of North Carolina will play host for the second straight year at a seminar on alcoholism for public health educators. The seminar will run from July 31 to August 4 and will be conducted primarily for graduate students in public health education and public health nurses, but will also be open to interested individuals working in the field of alcoholism. William Herzog, Research Associate in the Department of Health Education in the UNC School of Public Health, will serve as coordinator of the seminar. Dr. Norbert L. Kelly, associate director of the NCARP, will participate in the seminar as an instructor.

AUSTRALIA: Australians drink annually nearly twenty-four gallons of beer per capita. With thirty percent of the population total abstainers, the per capita average among drinkers is therefore much higher. The country's population of only 9,900,000 spends $526,400,000 each year for alcoholic beverages.

RALEIGH, N. C.: Summer Studies on Facts About Alcohol, a two-week study course designed especially for teachers and prospective teachers, will be conducted at three North Carolina colleges during the months of June and July. Sponsored by the North Carolina Alcoholic Rehabilitation Program and the participating colleges, the courses are scheduled to be held at East Carolina June 6-16; at North Carolina College June 9-21 and at Catawba College June 12-23. Serving as coordinators at the colleges for the courses are Dr. N. M. Jorgenson, Director of the Department of Health and Physical Education at East Carolina College; Howard Fitts, M.S.P.H., Assistant Professor of Health Education at North Carolina College; and Peter Cooper, Chairman of the Department of Sociology and Political Science at Catawba College.

SOUTHERN PINES, N. C.: A meeting of the Alcoholism Programs of North Carolina was held on February 23 at the Mid-Pines Hotel in Southern Pines. Approximately thirty-five representatives of local and state alcoholism programs were present. Primarily a business meeting, proposed by-laws for a more formal organization of the A.P.N.C. were discussed and referred back to committee for further work. The next meeting will be held in Durham April 21st at the Jack Tar Hotel.

WINSTON-SALEM, N. C.: A Ministers' Institute on Alcoholism, sponsored by the Forsyth Ministers Fellowship in cooperation with the Alcoholism Program of Forsyth County and the North Carolina Alcoholic Rehabilitation Program, was held on March 6 at the Winston-Salem Y.M.C.A. During the morning session, NCARP associate director Dr. Norbert L. Kelly spoke on "A Cultural Perspective of Alcoholism" and Miss Roberta E. Lytle, psychiatric social worker at the Alcoholic Rehabilitation Center at Butner, N. C., spoke on "Counseling the Alcoholic." Another Ministers' Institute on Alcoholism was held in February in Morehead City, N. C. It was sponsored by the Carteret County Ministerial Association and the Committee on Alcoholism of the North Carolina Council of Churches.

Wishes to Help Friend

I have a dear friend who is an alcoholic. Will you please send me information on how I can help her? It will be greatly appreciated.

Anonymous
Kings Mountain, N. C.

Valuable Information

I enjoy your publication, *Inventory,* very much. I find a lot of valuable information in it which I am able to use in my work as a safety representative of the North Carolina Industrial Commission.

Bill Silver
Charlotte, N. C.

Useful to Coach

I have just had the opportunity to read the January-February issue of your magazine, *Inventory,* for the first time. It is a wonderful magazine and I feel it would be most useful in helping to bring information about alcoholism to the young people with whom I come in contact in my work as a coach and Sunday School teacher.

George F. Zuelke
Northfield, Minnesota

College Professor Writes

The article on the North Carolina Prison Department's alcoholic rehabilitation program is most timely and encouraging. Development of effective rehabilitation in the correctional institution is complex and difficult. I hope this article will contribute to the easing of the double stigmatization of the alcoholic and the role of prisoner. If we can divorce the treatable person from the minority of vicious criminals, the way will be cleared for effective rehabilitation.

Elmer H. Johnson, Ph.D.
Assistant Professor of Sociology
North Carolina State College
Raleigh, N. C.

Wishes to Reprint

I am the wife of an arrested alcoholic, an active member in Al-Anon, and have been receiving *Inventory* for several months.

Your current issue—January-February, 1961—was to me one of the best yet, since much of it dealt with the family of the alcoholic. There are four articles in this issue that our Al-Anon group would like to reprint. May we have permission to do this? The articles I refer to are: "Home Reconstruction—A Lifetime Job", "Alcoholism and the Family", "Al-Anon: The Answer", and "Why Psychiatrists Fail With Alcoholics."

"Home Reconstruction — A Lifetime Job", in particular, struck home with many of us in our Al-Anon group and we feel that every member of AA should read it. It pointed up answers to what we have been "groping" for, as the missing ingredient, for a long, long time. We believe if it is circulated that it can really be the bridge to complete happiness for the alcoholic and his mate.

Anonymous
Al-Anon Group
New York, N. Y.

VOL. X, NO. 6 INVENTORY MARCH-APRIL, 1961

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

DESTINED TO FAIL

By VERNELLE FOX, M.D.

A positive attitude toward daily living plus faith in oneself are keys to turn failure into success.

WE frequently spend a good deal of time in group therapy looking at why Joe or John has been such a "failure." A failure both in general living, getting along with people, and in his attempts to stay sober.

A number of basic reaction patterns seem to emerge. To see yourself as a failure will almost invariably lead to failure in whatever you undertake. It's failing because of the failing that very much resembles drinking because of the drinking.

Joe said he had always felt left out and not really an important part of anything—including his own family. He lived in dread of having doors shut in his face—of being turned down if he asked for anything, whether it be a love, a job, a chance to use his talents or anything. How to live with such a nagging fear? That's simple. Just convince yourself that you don't care anyway. If you work hard enough at it you can

almost believe it. You can most certainly sell other people on the idea. Joe occasionally asked for something but, being a good salesman, he convinced the other fellow that he really didn't care much whether he got it or not. So he didn't. This just proved to Joe that he was right in the first place. People must consider him "no good" because they wouldn't give him the things he really needed and deserved. People didn't consider him "no good"—he did—and so on and on the cycle went. The more he expected to be turned down, the more he *was* turned down.

ABOUT THE AUTHOR

Dr. Fox was appointed medical director of the Georgian Clinic in 1956. She has had numerous articles published in leading periodicals and frequently presents lectures on alcoholism. In 1956, she was Atlanta's "Woman of the Year in Professions."

The same kind of attitude cannot only make you fail at living, but can eventually serve as a means to keep you from even trying. John said that each time he sobered up, he looked at the vast amount of hurt and harm he had done. It was a veritable mountain and seemed to completely overwhelm him. Only one solution could come into his mind. He must do a mountain of "good" to offset the bad. This was such an overwhelming task that he didn't know where to begin. The more he studied it the more impossible it seemed. He would become so frightened facing this impossible task that he would start drinking again. And so, on and on, not only did he not do his mountain of "good", but he continued to add to his mountain of "bad."

Living Today

One day John began to realize that absolute defeat is built into this kind of attitude. He said to himself, "It would take two lifetimes with eight good men helping me to do this," so he simply gave up the whole idea, accepted the fact that he couldn't do it, and set out to do what he could toward living today.

Living today is not an impossible task. Regardless of the past, each one of us is capable of doing a reasonable job of that. If we attempt something that is possible we will succeed part of the time—we won't always fail. With each successful day of living comes a little more faith in your ability to live another successful day.

Joe began to realize the same thing, only with different words. He gradually came to know that surely he had failed—many times for that matter—but did that really mean he *was* a failure? There's a real difference. One is an event, the other a permanent state of affairs. Joe realized that he had parleyed a series of events into a *real thing*. This put a new light on the situation. It meant that in truth, tomorrow is another day. In spite of the door that was shut in his face yesterday, he began to realize that other doors possibly might be open to him today.

Our Own Attitude

At first it seems frightening to realize that we ourselves control our "destiny." It seems much easier to blame the world or "fate"—but is it? If our own attitude about ourselves has this much to do with it, then we are not really destined to fail!

Reprinted by permission from THE NEW LIFE, published by the Georgia Commission on Alcoholism

ALCOHOLISM—A WASTEBASKET REVOLUTION

Society has long used the custodial method of disposing of alcohol problems. A revolution is underway that could change this ineffective custom.

By RALPH L. DANIEL, M.S.W.

Ralph Daniel is Executive Director of the Michigan State Board of Alcoholism. Prior to his appointment, he served as an Educational Consultant with the State Department of Mental Health. He has served as a consultant to many alcoholism programs throughout the country.

"IT was good for Paul and Silas, and it's good enough for me." The words of the old song constitute an interesting comment on human nature. In some areas, change is not popular, and those who desire to change old customs and habits and practices must proceed cautiously.

For countless generations, society has known that there are problems relating to the use of alcohol. In spite of honest and energetic efforts on the part of those who would like to eliminate the problems by eliminating alcoholic beverages, the custom of drinking these beverages has persisted. People who want alcohol available but who can offer no solution to alcohol-related problems, seem to want to hide and evade them. It is almost like tossing alcohol problems into a wastebasket and delegating to certain custodial persons the job of emptying the basket, disposing of the waste material, and returning the basket to be filled again. Society has not been much concerned about how the custodians got rid of the trash, as long as it was out of sight and didn't blow around and clutter up the neighborhood. If the janitor could salvage any waste material or if he could give it to the Salvation Army, that was his business.

People who call alcoholism a disease, and who advocate treating alcoholics as sick people, are actually proposing a change in old and well-accepted customs. They would do well to examine the custom, clearly define their goals, and map out their strategy for reaching the goals.

For countless generations, society has tossed many things into a wastebasket labeled "alcohol problems." Dig through this wastebasket of common usage and you find drink-

ing drivers, skid row, jokes about drinking, delirium tremens, regulation of the liquor traffic, pledge cards, temperance programs, acute intoxication, "the life of the party", rescue missions, Alcoholics Anonymous, alcohol-related accidents, prohibition, cocktail parties, absenteeism, drunkenness, the liquor interests, teen-age drinking, "taking the cure", lost weekends, divorce, disorderly conduct, alcohol addiction, neglected children, and a lack of will power. Posting on this basket a label that reads "Alcoholism Is a Disease" will serve no good purpose. It will only cause confusion and resistance.

Varied Meanings

People who use the term "alcoholism" may be referring to any of a variety of alcohol-related problems. Some people consider teen-age drinking to be an alcoholism problem. Some people hear the word "alcoholism" and they think of the homeless man on skid row. There are those who believe that cocktail parties are alcoholism problems. Many people consider intoxication and alcoholism to be the same thing. The drinking driver is an alcoholism problem in the minds of some people. And there are many others. No well-informed person considers these to be health problems, but to people who hold these definitions, the naked statement "alcoholism is a disease" is confusing and unacceptable.

For countless generations, society has tossed into the alcohol problem wastebasket a variety of alcohol-related problems. For countless generations, society has hired custodians to empty the wastebasket.

The many laws that have been passed to protect society from the results of excessive drinking assign custodial duties to courts and law enforcement agencies. Relief and charity agencies assume custodial duties when excessive drinking causes loss of income and family conflict. Hospitals and physicians assume custodial duties when they treat only the physical results of the excessive use of alcohol and ignore the causes of excessive drinking.

The custodial method of disposing of alcohol problems is not a very effective method, but it is old and it is well accepted. It has been deeply rooted in cultures faced with problems they could not understand. It will not change quickly.

The demonstrations of the successes of people who treat alcoholics as sick people will eventually change this particular problem from society's custodial agencies to its treatment and rehabilitation resources. The change can be either evolutionary or revolutionary. Evolution will take two or three generations of unplanned progress. A revolution could accomplish the progress in less than one generation.

The trouble with revolutions is that the planners are generally shortsighted. They plan strategy for overthrow of the status quo but they fail to plan what they will do with the victory. Revolutions develop heroes well qualified to win wars, but poorly qualified to establish new cultural patterns and new methods of handling the hard-won victories. Many revolutions present brilliant military strategy and stupid and chaotic reconstruction periods because they failed to develop new peacetime heroes.

Being a war hero is a satisfying thing. Sometimes war heroes look ahead to the end of wars and they fear a prospect of becoming ex-heroes. These fears can prolong revolutions. They can extend wars. Success breeds a thirst for success that may prolong the conditions that

produced success.

The alcoholism revolution is almost won. The banners declaring alcoholism to be a disease are well planted in strategic places. The general public is mouthing the words, "Alcoholics are sick people who need help." Now is the time when new heroes must be developed. Now is the time for leaders skilled in building social action and cultural change. The success of the alcoholism revolution depends on what society does with the new-found truth. The day is in sight when the alcoholic will be freed from the wastebasket. It is time to plan for new methods and new leaders and new workers.

A four-point reconstruction program seems expedient:

1. The victory must be clearly defined; alcoholism must be separated from other alcohol-related problems.
2. The masses who use the wastebasket must learn to truly accept alcoholism as an illness.
3. The custodians must learn to use their authority to channel the alcoholic into therapeutic areas.
4. Society's therapists must learn to adapt their skills to meet the differences between the new patients and their other patients.

The alcoholism revolution has almost won the shooting war. The eventual success of the revolution depends on whether society simmers down to a warm, humane treatment of a real problem or whether it plunges into a cold war between the war heroes who proved that alcoholism is an illness, and the people potentially capable of incorporating the victories into the culture.

Mental Health Is EVERYBODY'S Business

BY TERRY SANFORD
GOVERNOR OF NORTH CAROLINA

THE fear has been expressed by some North Carolinians in recent years that, in what appears to be our state's increasing preoccupation with economic progress and the acquisition of material wealth, we have, as individuals and a state, lost some of our traditional compassion, some of our genuine concern for one another as human beings. I have never shared this view and would never have acknowledged its existence had it not occurred to me that if dramatic evidence is needed to dispel such fears, it is to be found in great abundance here this evening at the annual meeting of the North Carolina Mental Health Association. Your interest in the program of this Association, and especially your participation in this meeting, is a tribute to each of you individually and reflects credit on our entire state.

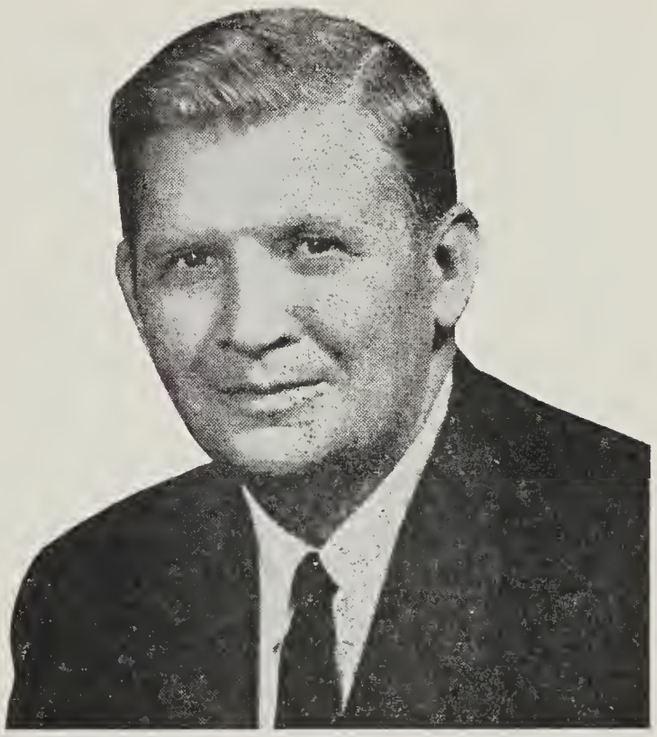
I would particularly like to commend the Association on the very fine program it has arranged for this two-day conference. It is gratifying to note that you are giving considerable attention to two aspects of the mental health picture that I regard as singularly important at this time —our mentally retarded children and the need for insuring an adequate supply of highly trained and properly dedicated people to administer this program with maximum efficiency.

This is not to suggest that we should be less enthusiastic about every facet of the mental health program. On the contrary, all activities must be attended to so that every citizen of North Carolina confronted with this problem can be assured of the best possible care and treatment.

This obligation is ours, not alone as public officials, but as responsible citizens, as conscientious members of society and as human beings.

This meeting, indicative, as it is, of the energetic battle being waged by this association to continually raise our state's standard of performance in this field, is striking evidence of our willingness to accept the challenge imposed by this obligation. This dinner, honoring the directors of our mental health clinics, points up the importance of this kind of activity and the dedicated people who administer it. It shows, in a very positive way, that we are gaining

This article is a condensation of an address made by Governor Sanford at the annual meeting of the North Carolina Association for Mental Health held in Raleigh on February 16 and 17 at the Hotel Sir Walter. The Governor summarizes progress being made in mental health fields in North Carolina and calls on all citizens to help.



momentum, that real progress is being made, both in our physical ability to cope with the complexities of this problem and in our understanding of the problem itself.

Those of you who have been closely associated with mental health work for any length of time are familiar with the difficult and frequently frustrating obstacles that are encountered almost daily in this program. But you are also familiar with the tremendous satisfaction that comes from the knowledge that your individual contribution, however small, has helped win one of the countless minor battles that must be fought successfully if we are to eventually triumph in the war on mental illness. The struggle has never been an easy one. It is not easy today and it will not be easy in the days that lie ahead. But you can find strength in the conviction that progress is being made. You can find consolation for your disappointments in the significance of every small achievement. And, if need be, you can find your personal reward in the sight of a lonely child emerging from a world of hopelessness and fear to experience, perhaps for the first time, the peace of mind, the security that comes with love and understanding.

This, of course, is the humanitarian approach to the mental health problem. It is the approach that appeals to our compassion, to our inherent concern for the well-being of our fellowmen. It is, and should be, our first consideration in all our activities in this field. It should provide the incentive for everything we do.

But there is a practical side, too. There is a dollars and cents incentive. When we consider that more than half a million Americans, almost half of the nation's hospital population, are mental patients, we get some hint of the economic burden created by mental illness. Add the fact that around 33 per cent of the general hospital patients and 50 per cent of the people who visit general practitioners regularly suffer from some form of mental illness and the magnitude of the problem becomes even more imposing. It becomes almost frightening when we realize that these statistics, alarming as they are, do not include undiag-

nosed cases or the countless thousands who stand on the fringe of mental illness—the alcoholics, the senile, and others who have lost the capacity for measuring up to accepted social standards.

Even if we could discount the social implications of this tragic situation, the enormity of the economic impact should be sufficient to erase any thoughts of complacency that might arise in the near future. It is a two-edged sword, cutting deep into the economic muscle of the nation. Not only does the tremendous cost of hospitalization and treatment sap our financial strength, but we are, at the same time, robbed of the vast productive potential of this segment of our population.

First Concern

Of first concern is, and will remain, the individual human being caught up in the tangled web of mental illness. But when we combine this humanitarian concern with a realistic appraisal of the economic and social factors involved, we bring the whole problem into proper perspective and see clearly the immensely complex challenge we face.

The challenge is a national one, but it holds special significance for us here in North Carolina. We are, by tradition and certainly by choice, a closely-knit community of people, deeply and genuinely concerned about the health, happiness and well-being of our neighbors and friends. We share our triumphs and defeats, our joys and disappointments. We share a humble, yet proud, heritage that has endowed us with a unique capacity for emotional involvement in problems affecting our fellow North Carolinians. For this reason, the people of this state are becoming more and more interested in mental health each day. That interest will manifest itself in the form of all-out support of our mental health program. In a situation as tragic as this, we have only to make sure that the great mass of our people comprehend fully the seriousness of the problem. There is ample precedent to indicate that they will rise to the challenge.

North Carolina is, of course, vitally affected by the economics of mental illness—more so, perhaps, than any other state in the nation. This is because we are at a critical point in our economic development program. We are at the point where the full productive capacity of every citizen is needed to man the machinery of progress. We realize that we simply do not have the knowledge needed to bring many of the patients in our mental institutions back to the status of useful, productive members of society. We know our responsibility to these people and we will meet that responsibility.

There are many others—rendered unproductive by our present knowledge, techniques, and facilities—that can be reclaimed, that can be given the help that will enable them to contribute to society. New knowledge —the product of our expanding research activities—is the only solution for some of our mentally ill. Others can be given a purpose in life simply by providing the facilities and the personnel for adequate diagnosis, treatment and rehabilitation.

Real Incentive

We can find real incentive in the knowledge that our investment of time and money in our mental health program will be repaid many times by even moderate success in the attainment of our objectives. One significant break-through in the medical or psychiatric field could boost this state's productive capacity sufficiently to more than compensate for the investment we have made, or will make in the future, in mental

health.

I do not think it is necessary to explain to this audience that this approach is not as impersonal as it sounds. For it is clearly compatible with the basic objective of any mental health program—that of returning the mentally ill person to a normal position in society.

North Carolina can, I feel, find some justification for pride in the progress it has made in a relatively short time in this field. A quarter-century ago, our state ranked 47th in the nation in the quality of its mental institutions and the care it afforded its patients. Today, we stand in the top 20 in the general quality of our mental health program.

Progress Made

We can be particularly proud of our progress in dealing with mental retardation. Our Caswell Training School for mentally retarded children at Kinston has been described by an official of the National Association for Retarded Children as the finest such facility in the nation. Especially noteworthy has been the work of the Caswell Rehabilitation Center which began operation last July to meet the specific needs of the mildly retarded and older victims of mental illness preparing for increasingly responsible roles in society. The relatively new Murdoch School at Camp Butner has also been recognized as an outstanding addition to the state's mental health program. In addition to the regular activities, this school is expanding its facilities for dealing with emotionally disturbed children. One unit of a diagnostic center for this purpose is in operation and plans have been made for expansion. Plans for expansion are also under way at O'Berry School in Goldsboro; and construction is expected to begin in the very near future on the training school to be established at Morganton.

This, of course, is only part of the progressive mental health program being carried out in the state, but it is indicative of our determination to meet this responsibility. We can be proud of what we have done and what we are doing, but we cannot rest on our laurels.

We know, for instance, that three per cent of the children born in North Carolina this year will eventually require treatment for mental illness. Next year, the percentage will be the same and the same will be true for the years to come, barring, of course, some medical advancement that will reduce this well-established average.

Taking all these factors into consideration, and adding the obvious fact that the significance of each will be increased by our population expansion, it is apparent that even our ambitious plans today will be inadequate tomorrow. We can be encouraged by the fact that new treatment techniques and new drugs, which facilitate the earlier release of many mental patients from our state hospitals, has relieved some of the burden, but this advantage is nullified by rising costs and increased activity in other facets of the overall program.

Great Challenge

We are, in effect, just beginning to crack the surface of this difficult problem. Enough progress is being made to encourage us in our efforts to push forward. No longer is concern for the mentally ill restricted to the members of families directly involved and the few enlightened public officials, like our friend John Umstead, who have, for many years, battled public indifference on this matter.

I believe very strongly that the new attitude toward mental illness

is reflected in the fact that of the $65,000,000 recommended to the Legislature this year as the amount needed to meet this state's responsibilities in the health field, approximately $45,000,000 represents the cost of continuing and expanding operations of the mental hospitals and training schools for mentally retarded children and the extension and enrichment of related programs administered by the State Board of Health. I believe also that this attitude was reflected less than a year and a half ago when the people of North Carolina approved the issuance of $12,053,000 in bonds to finance the expansion of mental health facilities.

The stage, then, is set for a period of dramatic progress. Many questions remain for which we will have to work diligently to find answers. But the answers will come because they are being sought by dedicated people.

One of the answers, most certainly, lies in greater activity at the community level—in the mental health clinics, the half-way houses that smooth the transition from institutional care to complete social responsibility, the classes for trainable mentally retarded children administered by local school units, and the various other programs that contribute significantly to the over-all mental health effort. I want to commend each of you here on the pioneering role you have played in these local programs. At the same time, I would like to urge you to even greater effort in this kind of activity. You can go forward with the assurance that you have the enthusiastic support of the Governor's Office and the equally enthusiastic cooperation of the state agencies active in this field.

Much of the responsibility for North Carolina's future success in combatting mental illness rests with the people who have gathered here in Raleigh today. You know what must be done. You know what can be accomplished if we dedicate ourselves to the task. I feel that we can look to the future with confidence and optimism and that our progress will be limited only by the amount of effort and enthusiasm we devote to the mental health program.

It is a great challenge, but one that we shall meet, for we are a leader and intend to continue to lead.

MENTAL HEALTH REQUIRES

Mental health requires that a person have a genuine concern for human life, his own and that of others. At the same time the approach to mental health means a progressive release from the growing pressures of neurotic anxiety. Mental health requires the discovery and exercise of one's inherent creative powers. At the same time, there can be no mental health which is not flexible and adaptable, and which considers the values of socialization and conscience as well as those of expressing creativity. Mental health demands productivity and effort, making a real and not just illusory impact upon the world of things and of people. At the same time, mental health can exist only in persons who can relax, let go, experience a kind of abandonment, be able to stand outside themselves.

—The Rev. Seward Hiltner in "A Churchman Looks at Mental Health"

MENTAL HEALTH IS "MADE"

JUST like Governor Sanford said, mental health is everybody's business! The observance of Mental Health Week April 30 through May 6 should warrant the participation of every citizen to a greater or lesser degree. The least that should be expected of anyone is that he listen and learn. For, with the mental ill-health problem at its present magnitude and growing, much citizen action will need to be taken in the future—for the good of all. Sound citizen action can result only from concerned and informed opinion.

The question is more than whether or not present and future casualties of emotional and mental ill-health will receive adequate care and treatment. Prevention is the crux of the problem, and no disease has ever been prevented through treatment alone. As someone has said, "If treatment is necessary, prevention has failed."

The urgency of attacking the mental illness problem vigorously can be reduced to a relatively simple necessity—that of making vital decisions in a tension-ridden and extremely complex society. The ability to make the "right" decisions is becoming increasingly important in attaining individual, local, state, national and international goals. Individually, the ability to solve conflicts and make decisions relates directly to personal happiness and fulfillment. The sum total of individual ability relates directly to collective ability and ultimately to solving survival-type problems facing the free world—and the rest of the world, for that matter.

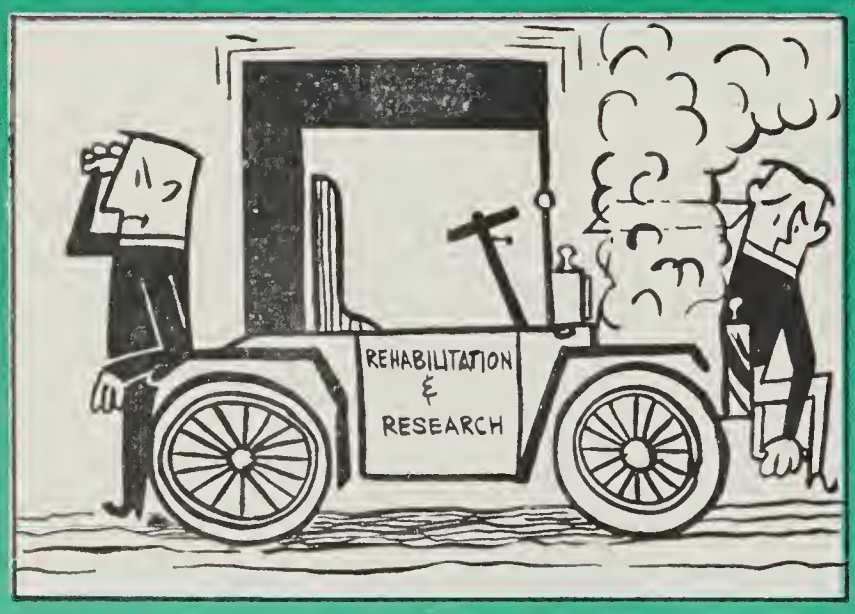
This is a task for the mentally healthy, and mentally healthy people are "made" not born. If we are to make mental health a reality, we must, therefore, begin at the beginning—with the new-born babe. The latter, being helpless, cannot manufacture his own mental health. He must be guided: first by his parents, the church, the schools. It is during these early years, the psychologists and psychiatrists tell us, that the stage for future mental health or mental illness is set.

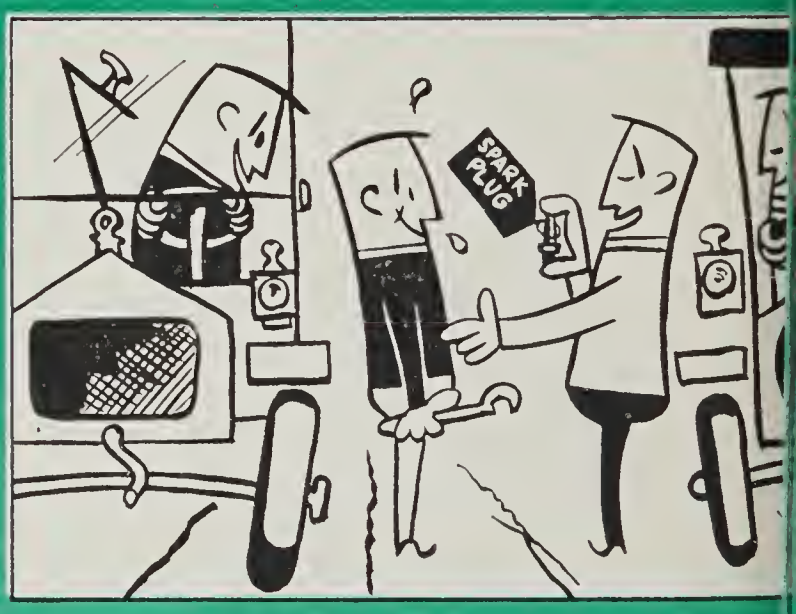
To accomplish our goal of "making" mentally healthy people, we cannot have the "blind leading the blind." We must spread the word, the principles of mental health, to present, prospective and future parents and teachers, to ministers, doctors and other key people of influence. To do this we must have trained "educators of educators." Then we must provide, and place in strategic spots, trained counselors and treatment personnel.

Education on the basis of what we now know is a prime ingredient of prevention. Another is the continuous search for new knowledge to apply and for the improvement of methods and techniques. We must first reach those who are responsible for the development of the very young with what we know. Then we must see that this knowledge permeates the whole of society which is obligated to provide its share of necessary services and facilities both in preventing and treating mental illness. (L.W.)

The Socia
Respo
in
Alcoholism

IN discussing the responsibilities of social agencies in the field of alcoholism, I have chosen to present the more general procedures whereby all agencies may cooperate in the establishment of a community group organized for the purpose of developing an effective approach to the problem. The vision and planning for specific action on the part of the agencies will evolve as the result of group discussions in the form of committee meetings arranged by the local organization. In this way, we can maintain a coordination of effort within a community without which





action may be spasmodic and individualized and techniques for meeting the problem either less effectively employed or not used at all.

I shall proceed on the assumption that there are certain basic concepts in the field of alcoholism which are already understood and therefore may be considered acceptable. These include the understanding that alcoholism is a public health problem and that it is, therefore, a responsibility of the public. On this basis it is possible to explore ways and means whereby the people in a community may be guided into active

By MARIA

The inspiration to initiate citize
action groups to combat alcoholis
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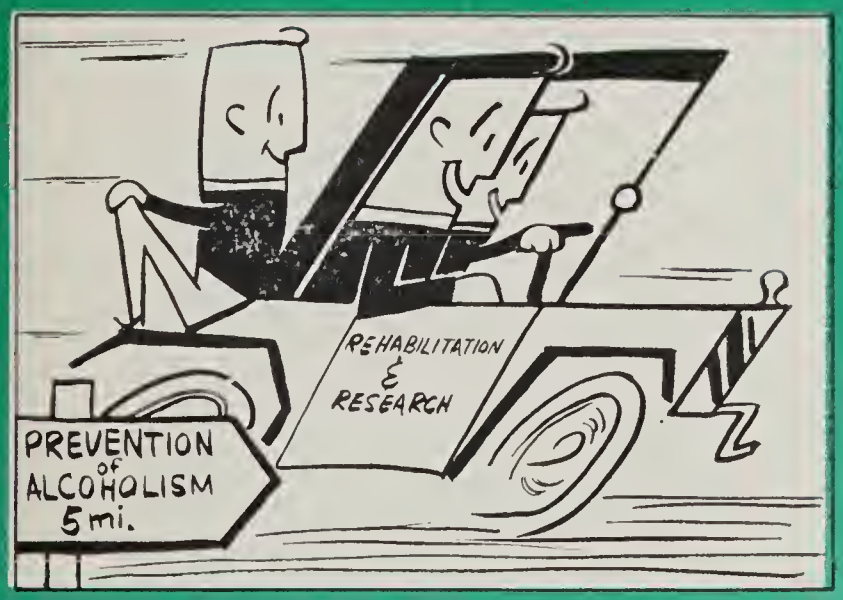
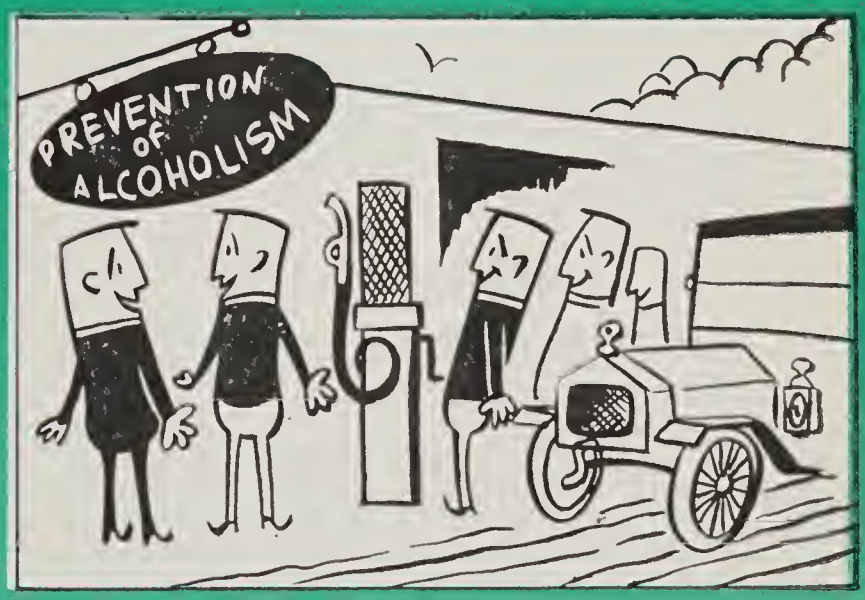




participation, accepting their responsibility to mobilize community resources with inspiration and energy.

By reviewing the early days of community organization in the field of alcoholism, I have attempted to sort out vital points which, had they been known earlier, would have made the entire process considerably easier. We know, for instance, that there are certain factors concerning the public and alcoholism which, if recognized and taken into consideration, can effectively assist the inauguration of community action. We need to realize that there have been built up in both drinkers and in nondrinkers alike definite attitudes and opinions which may or may not be conducive to our concept and full understanding of alcoholism as a disease. These may be so concrete, so reinforced by highly emotional feelings about beverage alcohol, that the establishment of an objective viewpoint, which other disease programs can take for granted, is an arduous task. There are those who have developed an apathy toward alcohol. These are persons who have decided to drink or not to drink and,

This article was originally given as a speech at the Annual Welfare Conference of the New Jersey Welfare Council. Reprinted by permission of the author. Marian J. Wettrick is Chief of Community Organization, Division of Behavioral Problems, Pennsylvania State Depratment of Health.

having no personal problem as a result of this decision, believe that their responsibility ends there. To create an acceptance of our program it is necessary to overcome false, biased ideas and to do this in a general atmosphere where practically everyone considers himself enough of an authority to advise and counsel those who tend to imbibe beyond the stage of propriety.

These facts are not discouraging; actually they present a challenge. It becomes apparent that the reconstruction of such attitudes is an undertaking which calls for action on the part of a large group of representative citizens. It logically follows that this type of voluntary community is fortunate enough to have among its citizens a few persons with the instincts of promoters, the ingenuity of diplomats, and the vision of crusaders.

Agencies Initiate Action

The individuals who, by the very virtue of their training and experience are the first to comprehend the existence of a real alcoholism problem within their communities and to suspect that the needs in that area are even greater than meets the eye, are very often those engaged in some aspect of social service. The inspiration to initiate a citizen action group has often come from social agencies in recognition of a responsibility. There are notable examples of this. In Rochester, New York, a very active Committee on Alcoholism came into being as the result of a six-year study of the problem by the Section on Alcoholism of the Council of Social Agencies. Another much more recent instance is the organization of the Lehigh County Committee on Alcoholism by the Community Council of Allentown, Pennsylvania. The executive director and board members of the Council assessed the community in terms of allies for the program. They wisely chose people of intelligence, drive, and good will who could further the interests of the Committee on Alcoholism and assist in maintaining them. This group is now ready to function as a separate unit, and should become self-sustaining since it is not the policy of the Social Agency Council to continue to operate such a committee.

Why is it that we attach such importance to enlisting citizen participation in public health movements? Because these are the people who will supply the initiative, the aggressiveness, the vision, the sense of values and the adaptability which together can result in successful achievement. We have witnessed the strong action of voluntary organizations in the form of temperance unions. Strongly supported by real crusaders in many localities, they have always been staunch citizens with a will to succeed. We all recognize the spirited forcefulness of this group. If the concepts about alcoholism which we have developed in the past few years are to take root universally, no longer clouded with foggy notions and misconceived attitudes, then throughout the country a similar intensity of citizen participation must be developed in the field of alcoholism.

Volunteers: Best Tool

There is no better tool for spreading the word, so to speak, than to enlist a large number of active members of a voluntary alcoholism committee who feel this movement to be their own. They will derive great personal satisfaction and inspiration, and as a result will seek every opportunity to interpret the problem and to explain the committee's activities.

In an organized community effort

the initial cooperation of the people can be assured only if the citizen committee has a "design for accomplishment" based on the establishment of specific goals and policies. In our attempt to create an understanding public, nothing is achieved by making ambiguous statements and expressing conflicting opinions. Without definite goals and policies, the committee's purpose may be channeled into irrelevant avenues only remotely connected with alcoholism, until resources are depleted without touching the problem of alcoholism at all. Early planning with a breadth of vision will eliminate the danger of becoming involved in one phase of the program to the exclusion of the less obvious ones. Consider, as an example, the glaring problem presented by the chronic abnormal drinker who repeatedly appears before the court. If a voluntary committee attempts to assume the major responsibility for remedial action in this area, it may find itself submerged and other equally important aspects of the problem impossible to fulfill. The community organization does have a responsibility in this area; however, it includes arrangements for cooperative planning and study on the part of those concerned, as well as promotion and guidance leading to constructive action. In one instance, a committee on alcoholism in New York State was urged for several years to establish a clinic in a county penitentiary in order to treat those chronic abnormal drinkers repeatedly sentenced to 30, 60 or 90 days. A Subcommittee on the Chronic Police Case Alcoholic was appointed. After considerable data were collected and a study made of similar facilities in other areas, a consultation was held with the Director of Alcoholic Research for the State of New York. The final decision of the committee was to conduct a research project in cooperation with the local university in order to obtain the information about the chronic police case alcoholic upon which to construct a more effective plan for rehabilitation.

Orientation Important

One essential in committee organization often overlooked by the voluntary committee is that of adequate provision for the orientation and indoctrination of all volunteers. This should include a thorough basic knowledge of alcoholism; the organizational policies and goals of the community organization; and a previously agreed upon procedure for explaining the overall purpose of a committee on alcoholism compared with Alcoholics Anonymous. The idea that these two organizations are one and the same is a common misconception in all cities where both exist.

As the need to consider specific problems and to plan in definite areas becomes apparent, subcommittees are formed. Constant awareness of all opportunities to include additional interested persons, as members on an active scale, is essential to progress.

Education is the keystone around which our aims and objectives are built—it has proven to be the basic foundation for successful programming.

Ultimate Goal: Prevention

Facts accruing from rehabilitation and research make possible the fulfillment of our ultimate goal—prevention of alcoholism. Allowing education to become a secondary consideration to that of rehabilitation is a mistake easily made and a danger in any community movement, since an intensified educational campaign acts as a spark plug for the provision

of ever-increasing facilities for treatment and care. The subcommittee on education may have three divisions: formal, professional and industrial. Consideration should be given to the development of a plan for education on the secondary school and college level. The committee responsible for this area can develop units of study, symposiums, conferences and in-service credit courses for teachers. The professional category should include specialized information on pastoral counseling of the alcoholic by the clergy and periodic programs for hospital medical staffs and for students nurses. It should include panel discussions for staff members of social agencies. It is well to spend time in planning these programs, making every attempt to suit the presentation to the needs and interests of a specialized profession in order that it may have some practical value for those in attendance. We know from experience that the wholehearted response of social agencies in the referral of cases, in agreeing to adjust procedures so as to facilitate a program of rehabilitation, and in willingly cooperating in the gathering and interpretation of materials for study has primarily resulted from a thorough and comprehensive interpretation of the alcoholism problem.

Effective Technique

An educational technique effectively used in one community was "Block Leader Plan." It is based on the theory that people are going to advise their neighbors on matters of health anyway, so we might as well arm them with correct information and arrange for its delivery into the homes by a block representative. This plan was used for alcoholism in one of our New York State cities, and I recall that it was necessary to curtail this educational technique when candidates for clinic admission exceeded available facilities.

Special committees for large group meetings, such as full-day institutes and annual meetings, may also be appointed. Care in selecting speakers, using well-worded themes, employing adequate publicity and giving variety to the programs induce a good attendance.

Information Center

A committee on alcoholism can be thought of as a community resource for scientific information on alcoholism; therefore, the establishment of an information center should be one of the first steps of a newly organized group.

Consider for a moment the situation in which a community has no facility for the treatment and care of alcoholics. The need is felt—the desire to see a clinic in operation is present—the statement that someone should do something is repeated again and again. This has in many cases provided the original impetus for the organization of a committee on alcoholism. This must not become its sole aim, however, since an organization with such a narrow sphere blooms only momentarily, fading out of existence at the completion of its project. A clinic subcommittee should function as a part of the overall group, to study ways and means for securing an alcoholism clinic. There should also be appointed a long-range planning committee to consider proposals for possible future facilities. Once a clinic exists, it may be desirable to organize an advisory council to establish policies and to consider administrative problems which may arise.

It is not always necessary to wait for state assistance. In one city a clinic functioned very successfully as a joint project of the medical society, the city health department and the

committee on alcoholism. It now continues to function under the same sponsorship but on a larger scale made possible by a grant-in-aid from the state.

Develop from Needs

In discussing the functions of voluntary organizations and the possible activities in which they may engage, it should be remembered that, since they develop from community needs, a 1-2-3 listing of progressive steps is not possible. Any examples to which I refer stem from a purely personal experience in already established committees on alcoholism, and so do not necessarily represent prescribed criteria for every community.

Many fine gestures may result from active participation of an individual in the alcoholism committee. In one city, the Chief of Police delegated to an officer in his department the special assignment to work with cases on alcoholism. This police officer sees that all those brought in for intoxication are his problem and he works closely with the courts, the city and county probation departments, and all social agencies. As a member of the executive group in the local committee on alcoholism, his work is coordinated with the total community plan, and his valuable advice lends strength to the entire program.

Steady Growth Best

The type of active community program which I have described does not burst into bloom overnight even under the ablest of leadership. Patience is a rewarding attribute, and it is often the slowly developing movement which is grounded in the firmest foundations. Some years ago, I heard of an ardent legislator who, in his enthusiasm, proposed a bill requiring by law that all general hospitals accept cases of acute alcoholism. The hospitals registered strong opposition and, fortunately, the bill died in committee. Motivation does not necessarily spring from legislation. One alcoholism committee functioned for five years before obtaining that objective. However, it was so well motivated that shortly after the meeting at which hospital administrators had unanimously agreed to accept acute cases, one of them called the committee headquarters and complained—"Two weeks ago we agreed to accept acute cases of alcoholism and not one has been brought in since that date."

Community Representatives

In Pennsylvania, the Department of Health's Division of Alcoholic Studies and Rehabilitation has in my opinion shown great foresight in appointing, as a part of its extensive program, community organization representatives for each of the seven public health regions in the state. As one of these representatives, I am happy to say that, in addition to education, our major duty is to promote the mobilization of community resources through the medium of active citizen's groups.

In closing, just this point about local committees on alcoholism. They should make every effort to interpret their program and to instill confidence in their policies and procedures, if they expect to secure effective relationships with social agencies. It logically follows, however, that the best way for agencies to assure themselves that the goals, policies, and practices are basically sound is to arrange for the active participation of representatives from the social agencies in the local alcoholism committee. And finally, it should be remembered that education is the sparkplug to facilities for treatment and care.

Medical findings promise to supplement greatly social and psychiatric research in the field of alcoholism. The combination represents a realistic approach to the problem.

A Medical Research Man Looks At Alcoholism

By H. Mac Vandiviere, M.D.

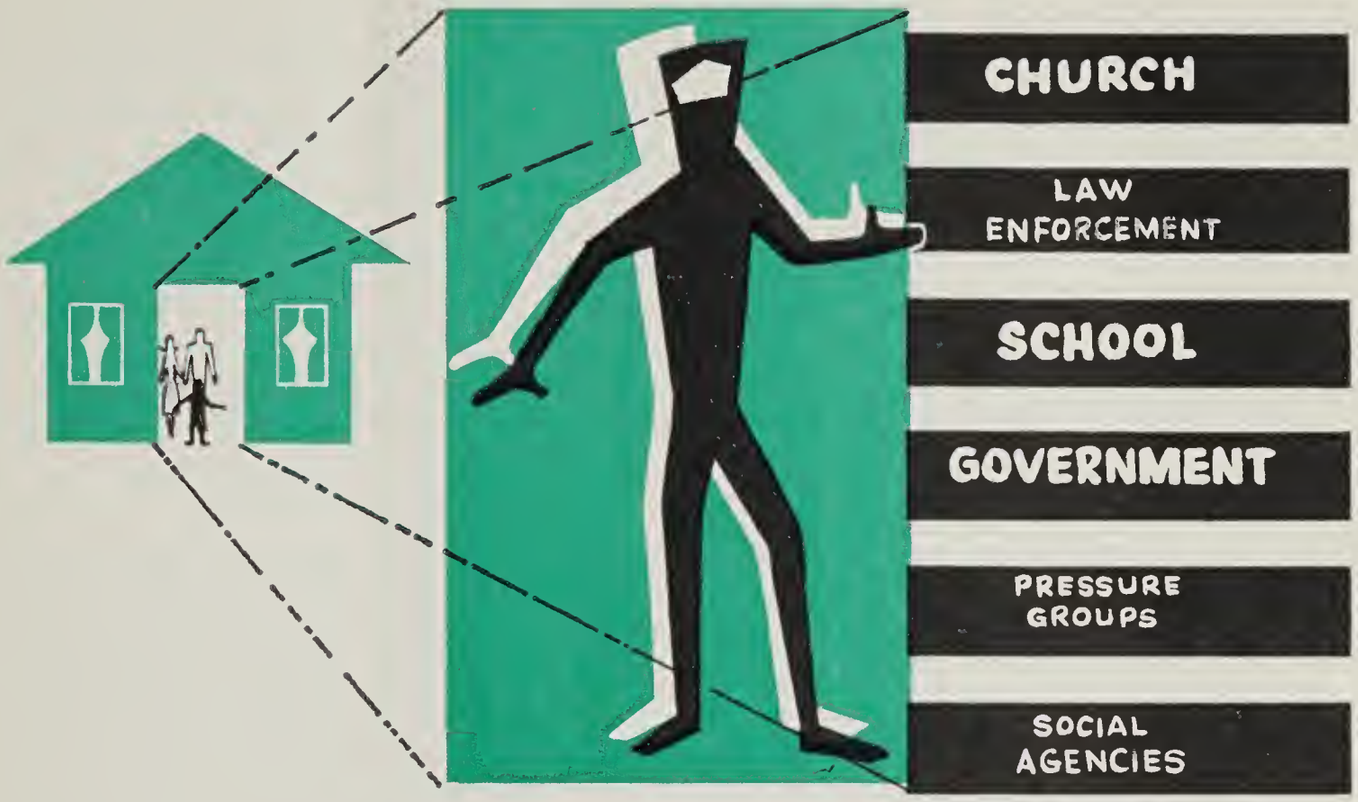
This article is based on a talk given by the author at an open A. A. meeting held in a church. The author wishes it understood that it was not his intention to imply that any one aspect of the illness, alcoholism, is more important than another. The significance of sociological and psychological factors was discussed more thoroughly by another speaker.

VERY often a discussion on alcoholism is likely to be full of pious dogma with little scientific fact. Why—in some ways—it is much like religion: Everyone has an opinion, most everyone knows a little, and no one knows the whole story. Thus, the basis for dogma and dictatorial concepts is laid. We substitute our lack of knowledge with the loud voice of inspirational dogma and then we add a moral doctrine.

We hear a lot about the alcoholic personality. Just what it is we aren't sure, anymore than there is a personality deficit in some category. But, then, who does not have some personality deficit? Again, we are told, alcoholics are compulsive personalities and, of course, they are—but so are most research men compulsive personalities. So the question is not one but several: What is the personality deficit and is it common or individualistic? Also, how and with what kind of a compulsive personality are we dealing? And is it merely misdirection of an acceptable compulsion?

Alcoholism is more than a personality problem, though, because there is a metabolic difference in the alcoholic. Thus, we have not only an "alcoholic personality" that can be aided and treated by Alcoholics Anonymous, the church, and the psychiatrist, but also an "alcoholic body" which craves alcohol as a substitute for another need and can be treated by the medical nutritionist. This body deficiency is likely to be just as demanding as the mind is in attempting to satisfy an unfulfilled desire.

The picture of alcoholism, however, is not yet complete. The "alcoholic personality" within the "alcoholic body," which, somehow, differs quantitatively from the non-alcoholic, is a product of a background and experiences lived within a society having its own mores, value



systems and views on alcohol. Furthermore, certain societies, through their value systems and views on alcohol, tend to enhance the development of alcoholism, and, at the same time, perpetuate it through their reactions to and treatment of alcoholism and its concomitant problems.

It is, therefore, apparent that alcoholism is not a simple disease. It is multiphasic in etiology (or cause); it is developmental, mental, physiologic and biochemical; and it is multiphasic in its signs, symptoms, and impact on the family and society.

The empirical proof of this multiphasic idea lies in the fact that the psychiatrist has stopped a few from drinking, the church has stopped a few, the individual himself has stopped on occasion, and still more have been stopped with the program of Alcoholics Anonymous. Less well known is that with dietary supplements some have been successfully treated. Probably the main point we must remember, however, is that alcoholics, although they may have some common qualities, are individuals and what is true of one is not necessarily true of another and, whatever the source of help, one success is worth twenty failures.

It is hoped that alcoholics can soon be individually studied metabolically and a dietary supplement used to aid in the treatment of alcoholism. So far, however, alcoholism is a medical as well as a social problem about which we know less than we do about pneumonia or tuberculosis. We know only as much about it, perhaps, as we do about cancer. The need to intensify research in alcoholism is therefore paramount since we know so little about the psychiatric, physiological, and biochemical aspects of the disease; yet, we know just enough to see the promise.

For instance: Many of us are aware of a loss of mental wisdom associated with alcohol consumption —but are you aware of just how far this level of wisdom goes? It is not just a loss of alertness, loss of moral wisdom, or loss of will power. It is much deeper in true alcoholism, as there was to begin with, or there does develop in the alcoholic, a nutritional deficiency and with this

deficiency there is a loss of wisdom of the body where anorexia develops and the body actually starves itself. This is more than loss of wisdom in selection of proper foods. It is loss of wisdom of desire by body as well as mind.

This nutritional deficiency occurring with alcoholism brings about a further decrease in mental as well as body wisdom of actual food requirements. A vicious cycle is set up where the beginning was to substitute for an unknown need and this triggers a whole chain reaction which grows worse with each cycle.

A similar phenomenon is seen in children whose diets are inadequate in minerals, proteins, and vitamins. This dietary deficiency causes the body to desire and accept more sugar, not because it needs sugar but because it misinterprets an unfulfilled need. Just as the reverse is true, and the child with adequate diet will crave and use less sugar, the person with adequate nutrition will drink less alcohol, even with no change in the dynamic emotional surroundings of the patient.

Unfulfilled Needs

To date the patients on whom this idea has been scientifically studied have been rats rather than humans. By special breeding, a strain of rats has been developed which is prone to develop a taste and even craving for alcohol. Other less susceptible rats will consume alcohol when placed on an inadequate diet. When both groups are placed on an adequate diet, the less susceptible rats give up the alcohol even though it is made available. Many of the alcoholic rats of the susceptible group will also give it up, but some of these will not give up alcohol consumption just because their diet has been made adequate. An explanation may be that their diet requirement is not really adequate due to a lack of knowledge of nutritional needs; another explanation may be a genetic difference in metabolism or use of alcohol; but there may well be other explanations. It appears, however, that a satisfied rat is not prone to accept alcohol. Certainly, the body with unfulfilled needs will seek a relief substitute as a human mind in turmoil will seek relief.

Realistic Approach

This is a glimpse into some of the more recent medical research in the field of alcoholism. The findings of the medical researchers in the basic underlying needs, causes, and effects promise to supplement greatly the social and psychiatric research in this field. The combination represents a realistic approach to the alcoholism problem.

The interest of the medical profession in the alcoholic is no new occurrence. Alcoholism is a complicating factor and often a cause of the physician's patients' physical and mental problems. A high percentage of the physician's patients are affected by problem drinking. During a two year period almost eight percent of the admissions to one general hospital were diagnosed as alcoholics. Some of these were admitted as accident victims, with gunshot wounds, fractures from falls, etc. The physician also has among his patients those afflicted with the serious conditions of fatty and cirrhotic liver disease brought about by the multiphasic influence of alcohol. He finds the conditions of gastritis, pancreatitis, anemia, ulcer, fatigue and nervousness more common among the alcoholic patients. They are more susceptible to disease, especially pneumonia and tuberculosis. Their nutritional problems are often acute.

In the past, the main interest of the medical profession has been in

dealing with the effects of alcohol on the body with the psychiatrist and psychologist seeking the underlying emotional needs in an effort to help the patient. Now medical research is delving into the causes and body needs as well as mental needs. The finding that a nutritional deficiency may be a cause as well as a result is significant in a developing, realistic approach to the total problem.

Sorely Needed

A realistic attitude and approach to the "alcohol problem" has been sorely needed from a social, cultural, and medical point of view. Many thousands of books and papers have been written on the subject. Much of these writings has been injected with emotional, political, and other elements which have made the problem even more complicated than it inherently is. Some of the investigations are being conducted by individuals and groups who "commenced convinced" and are committed in advance to a particular point of view. Invading this field of need have been many well-meaning crusaders, their thinking and approach befogged with emotionalism and dedication rather than critical evaluation and reason.

Medical investigators in the physical causes and solutions are joined in this new realistic approach with the psychiatrists and psychologists, who are seeking insight into the mental needs and forces at work in the alcoholic and his associates, and the sociologists who, in moving out of the realm of emotionalism and turning to a view of the culture in which the problem occurs, are now investigating the problem as it exists in the whole of society. All, more or less, have joined forces with the A. A. groups who offer understanding and support. Thus, alcoholism is being approached from its physical, biological, psychological, and cultural aspects.

Wherein does the responsibility for helping the alcoholic fulfill his needs and accomplish his rehabilitation lie? The responsibility cannot be placed in a single location. It must be shared by:

1. the government in having and enforcing realistic regulations of the control and distribution of alcohol,
2. the community in offering understanding and the opportunity for treatment and study of the problem,
3. the social workers in realistic approach to research and help,
4. the medical profession in offering treatment, both physical and mental, as well as research in the underlying needs and solutions,
5. the employer in offering assistance in obtaining help and the opportunity to reestablish financial security where desired,
6. the family and friends in understanding the problem and offering love and loyalty,
7. other alcoholics or A.A. members who may best understand the problem and offer help,
8. the minister, who may offer spiritual guidance and hope,
9. and last, and most important, **self**—the alcoholic must realize that all assistance is worthless without his own striving for an understanding of his problem and determination to overcome it.

Real Progress

We find now real progress being made through the efforts of the medical profession, A.A. groups, and interested individuals and groups. Many good things may be said about their efforts and accomplishments, but let us not be too smug in our pride at the direction of the realistic approach which is only beginning. There is a common fault in the approach to the problem by both the A.A. and the medical groups. Both

attempt to solve the problem by removing it. The problem was caused by a need—whether emotional or physical, or a combination—and must be replaced by something real; there must be a projection, a future potential, not a past.

In the child with a craving for candy due to a nutritional need, we would not remove the candy and substitute a more harmful substance such as alcohol or tobacco. No more can we just take alcohol away and leave the alcoholic in a void without hope of fulfillment of need, nor can we use an unacceptable or a more dangerous drug or narcotic. Neither harmful substitution nor void is the answer. Both groups—the A.A. and the medical profession—have in many instances failed to realize the presence of this need in the alcoholic. There must be some insight and purpose in the individual's life. Everyone, to succeed, requires purposeful motivation — some reason for existing. Different individuals will find this in different ways. Some will, within themselves, know what their motivation must be; others will be able to find it through their church or religion. Whatever the purpose, whatever the way, this necessity must be realized by both groups if their aims are to succeed. Remember, without basic needs fulfilled and without purpose, the victory will only be temporary or meaningless.

Satisfactory treatment must consist of a combination of an intensive psychological re-education approach reinforced by a sensible correction of physical damage with particular attention to a carefully considered nutritional program. In order for the victory to be lasting, the individual must find some purpose—to find satisfaction, success, efficiency, and happiness.

And with sufficient research, sociological, psychological and physiological, we may reach the ultimate goal and be able to detect the potential alcoholic and prevent the disease from occurring.

Dr. H. Mac Vandiviere, director of research for the N. C. Sanatorium System, is chiefly known for his contributions in basic and immunological research in TB but he is also noted for work in rabies, bacterial toxins, and dairy food science and nutrition. Scheduled for listing in the next issue of American Men of Science, he is a Fellow of the American Public Health Association in epidemiology and was recently appointed a consultant to MEDICO, an international voluntary medical group which provides services to underdeveloped countries. Dr. Vandiviere and his associates soon hope to fulfill a request of the Haitian government to set-up a TB control program in Haiti that would include the opportunity for a mass human evaluation study of the superior R[1] anti-tuberculosis vaccine developed in the research department. Initiation of the project awaits funds for carrying out the vaccination phase.

Our Parents Drink Too Much

By HERMAN E. KRIMMEL

The teen-age children of alcoholic parents have formed Alateen fellowship groups to better understand and cope with alcoholism and its effects on family life.

Herman Krimmel is Director of Casework Services and editor of the News *of the Cleveland Center on Alcoholism. This article, reprinted by permission, was originally published in* The American Weekly.

WHEN the dark, strikingly pretty 16-year-old girl rose to speak at the meeting of twenty teen-agers, an outsider might have assumed she was on her feet to discuss plans for a high-school prom or a church picnic. If so, the first quietly spoken words would have jolted the visitor.

"My name," began the speaker, "is Ruth M——. My father is an alcoholic. My mother and brother and I have just about reached the end of our rope. We don't understand him, and we don't know why he drinks and we just don't know how much longer we can take it. We need help."

The boys and girls in the audience were obviously sympathetic, but they were neither surprised nor shocked. At one time or another each of them had spoken similar words, because this was a weekly meeting of an Alateen group.

Alateens are the teen-age sons and daughters of alcoholic parents. Their fellowship is a unique effort to understand and to attempt to cope with the harsh problems that seem continuously to beset families in which one or both parents are compulsive

drinkers. Among themselves, these young people can "talk out" their fear and hurts instead of bottling them until they explode.

A girl like Ruth is confused and angry. Her father can be a generous, decent, warmhearted man when he is sober but she can never be sure when that will be. Sometimes he is sober for a few days, sometimes for several weeks. During these periods family life might be "the greatest" if it were not for the relentless uncertainty.

Loss of Control

Ruth and her mother and younger brother are always waiting for the dreaded moment when he will take "just one little drink to relax." He will never stop with that one. He will go on drinking until he is too sick to take another drop. He will make a revolting spectacle of himself. He will alternate between sloppy sentiment and the vilest abuse. He will accuse his wife and children of making his life so miserable that he has to drink.

He may, as he has so frequently, savagely slap his wife for some imagined affront and fail to remember anything about his behavior the following day. When the binge has spent its force, there will be hours or days of recovery when Ruth sees her father not as a man but as a whimpering child crying out his guilt and begging forgiveness.

The first thing Ruth learned in Alateen was that she was not alone. She was not the only girl afraid to invite friends into her home because of an unreliable parent. Hers was not the only home in which broken promises were the rule rather than the exception. There were others who tossed through sleepless nights because of bitter parental quarreling in the adjoining room. Talking about these things didn't change them but it did increase her understanding—the first vital step.

Ruth realized, for the first time, that alcoholism is an illness and not a deliberate sin nor a moral weakness. Moreover, it is an illness that afflicts between 4½ and 5 million adults in the United States. Later, like most Alateens, she could say that the day she recognized that fact was one of the brightest in her life.

As one boy told me: "You don't know what a relief it was to look at my father and know that he wasn't a bum—just a sick man."

This knowledge provides new freedom to many youngsters—the freedom to love their parents. It can be difficult to love a person who seems to be intentionally selfish and cruel. Knowing that he is sick can make a big difference.

One of the most formidable obstacles to the conquest of alcoholism—rated by many authorities as the nation's third or fourth most serious health problem—is the public refusal to accept it as an illness. The moral stigma persists and alcoholics and their families, instead of seeking help, withdraw to avoid the pointed finger.

Any Walk of Life

Actually, not more than 5 to 7 percent of alcoholics are on Skid Row. The alcoholic may wear the grey flannel suit of Madison Avenue, the grimy jeans of the steel mill, or the antiseptic jacket of the physician. Problem drinking is no respecter of education, neighborhood, economic status or vocational training. Too many children, however, suffer long years of shame before they learn that alcoholics can be "nice" people. Some learn it first in their Alateen group.

Ruth had the same questions as many other newcomers. For example, could she inherit her father's alco-

holism? She was assured that there is no evidence to support any such fear. Was it her fault, perhaps, that her father drank too much? Sometimes her own convictions were shaken by the incessant pounding of his drunken accusations. The group discussions taught her that most alcoholics, in their frantic need for self-justification, become incredibly skillful at shifting the blame onto the supposed faults of others.

The questions discussed at a typical meeting are of infinite variety. A member groping for guidance wants to know if a teen-ager should obey an alcoholic when he is drinking. The general feeling is that he should if the request is reasonable. Another wants to know if a child should make special amends to a parent if he or she sobers up. The response is that praise and encouragement are in order, but servility or excessive sentimentality are not. They talk about ways and means of dealing with economic insecurity, how to avoid being "used" by battling parents, about social and moral values, about divided loyalties.

A girl at one meeting wanted to know what to say to friends when they saw her father drunk. She was counseled to tell the truth and say that her father was a sick man but also let it be known that she firmly believed he would recover some day.

A boy, worried because his friends had stopped visiting his home, was cautioned against trying to force them but encouraged to continue his participation in group activities. "Show them you are not ashamed of your father and that his illness has not changed *you*."

In this age group it is to be expected that many discussions focus on dating and the special problems it presents to the child of an alcoholic. One girl reported that she had long refused dates, made innumerable excuses and frequently evaded the truth. With the help of her Alateen friends, however, she had reached the point of being able to say to her boy friend without embarrassment, "I'll meet you out tonight, my father is drinking."

The philosophy of Alateen is impressively realistic for people so young. They are intolerant of self-pity. They know that their problems are tough but they know also that running away is no solution. One boy thought that his father was "the meanest and biggest drunk there ever was." He retaliated by doing things he knew were wrong and by running away from home. Of course, it didn't work. In Alateen, it finally got through to him that he was hurting only himself.

A 14-year-old boy conceded that it wasn't until he joined Alateen that he woke up to the fact that his mother wasn't going to stop drinking just because he went out and stole cars. A 17-year-old girl credited Alateen companions for making her see that flight into what would have certainly been a disastrous marriage would not make any sense.

Spiritual Strength

The knowledge that Alateens have each other is a fortress of strength. But it is not enough. They know that above all, they can turn to God for ultimate help in their trouble. Seldom are prayers more heartfelt than those which open and close every Alateen meeting. Then they vow to "search our hearts for weakness so we may deserve Your help." These boys and girls know that their program is a spiritual one in its deepest sense.

Alateen has drawn heavily on the experience of Alcoholics Anonymous and has its own 12 steps. The first is the acknowledgment that families,

too, are powerless over alcohol. With the acceptance of that principle and with the guidance of God as they understand Him, they are better able to help the victims of alcoholism.

Like members of the parent organization, Alateens are encouraged to live one day at a time. Instead of fretting about what will happen "if my father never stops drinking," they come to believe that "you can endure something for 24 hours that would appall you if you had to keep it up for a lifetime." Moreover, they learn that there is always hope for the alcoholic—which can be an almost bottomless reservoir of encouragement.

Twelfth Step Work

Alateens look at themselves hard and objectively to find out if they might unwittingly be helping to make things worse instead of better. A common failing, they discover, is a tendency to favor one parent over another. This only fans the flames of parental conflict.

"Twelfth-step" work is of the utmost importance. Those who have solved their own problems concentrate on helping others. As one boy observed, "We learn that it is in service to others that we help ourselves." Many adults, unfortunately, never learn that lesson. The points of similarity to Alcoholics Anonymous is not surprising.

The Alateen idea was born in 1956, in Pasadena, California, in the mind of a high school boy named Bob. His father had been helped in A.A. but there were still fairly acute family problems. Bob had attended some A.A. meetings with his parents and decided that many of the principles and techniques could be helpful to the children of alcoholics. He also saw that they woud be most effective if practiced in their own age group rather than mixing with adults.

On a historic Wednesday night, six young people assembled in a suburban kitchen for the first Alateen meeting. A year later they had 21 members. Today there are more than 60 active groups throughout the United States and Canada and another 50 in various stages of organization. The idea has traveled as far as Australia. In an isolated section of Ireland, two sisters have formed their own Alateen group with a total membership of two.

Similarities to the parent group should never be mistaken for dependence. Alateen is strictly a teenage affair which uses the insights of Alcoholics Anonymous and of Al-Anon, which is the organization of non-alcoholic spouses. It cooperates with both but is proudly independent of both. "We talk freely among ourselves," explained one girl, "and we get a lot more out of it if there are no adults around. We just clam up when they are with us."

Alateen does not provide all the answers. But it does provide understanding. It also provides friendship to boys and girls who had been so afraid people would unmask their secret that they were in danger of growing up without friends.

During a recent conversation, Ruth summed it up. "Alateen," she said, "changed my attitudes and feelings toward my father. And when he knew that I, as well as Mom and my brother, thought of him as sick rather than bad, he began to see himself that way and realized he might be able to do something about it.

"Sure, we still have problems and sometimes I get to feeling sorry for myself. But it isn't nearly as tough as it was. In Alateen I can always feel at home. That's important. I can be *in* when, always before, I felt so *out* of it all."

The Disease Concept of Alcoholism. By E. M. Jellinek. (New Haven: Hillhouse Press, 1960, 240 pp., $6.00.)

* * *

Alcoholism: An Interdisciplinary Approach. Edited by David Pittman. (Springfield, Ill. Chas. C. Thomas, Publisher, 1959, 96 pp., $3.75.)

* * *

Origins of Alcoholism. By William McCord and Joan McCord. (Stanford, Cal.: Stanford Univ. Press, 1960, 193 pp., $4.75.)

* * *

Tomorrow Will Be Sober. By Lincoln Williams. (New York: Harper & Bros., 1960, 208 pp., $3.00.)

Books of Interest

In **The Disease Concept of Alcoholism,** Dr. Jellinek reviews the numerous psychiatric, nutritional, endrocrinological, pharmacological, sociological, economic, and allergy theories of alcoholism. He then posits his own working hypothesis of the illness. Jellinek believes the gamma species of alcoholism, one of several species he delimits, is the most prevalent type in North America. The gamma species he suggests, progresses from psychological maladjustment to pharmacological addiction. The author maintains that future research on alcoholism in the United States should concentrate on the pharmacological process in addiction that eventuates in physical dependency.

A somewhat different view of research needs is pointed up in the Pittman volume. This work reports the proceedings of a research conference on alcoholism at Washington University. It includes the conclusions of the several discussion groups as well as the remarks of the speakers. Two of the groups emphasized that much more research attention must be given psychological and sociological areas. A third stressed the great need for investigation in all relevant areas. One finishes the book, subtitled **An Interdisciplinary Approach,** with the distinct feeling that teamwork involving different disciplines is largely still an ideal. The actual mechanics of interdisciplinary research present real practical problems, not the least of which is discipline bias.

One of the discussion groups at the Washington University conference suggested that those interested in longitudinal research projects in alcoholism might overcome the handicap of time by using data collected in earlier years for other projects. This is exactly what the McCords did and reported on in **Origins of Alcoholism.** By analyzing data originally collected for the Cambridge-Somerville Youth Project in the 1930's, the McCords conclude that the male alcoholic is reared in a family background of general stress. This creates in the growing child a high degree of insecurity. Out of this disrupted background is developed a severe dependency conflict. This, the authors believe, may be the principal factor underlying alcoholism. They emphasize also that the male alcoholic, because of inadequate parental model, never adequately learns the adult male role. It would be interesting to compare the results of the present study with one not based primarily on lower social class subjects.

The three books briefly discussed above are directed at professionals and attempt new insights. **Tomorow Will Be Sober** is more for the lay audience. It recapitulates much that has appeared in numerous other sources. The author discusses, for example, the nature of alcoholism, types of alcoholics, and kinds of contemporary therapy. Attention is given to Alcoholics Anonymous and spiritual therapy. The book is simply written and easily read.

—Norbert L. Kelly, Ph.D.

Currently In North Carolina there are twelve

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—
Citizens' Committee on Alcoholism
Rev. Robert L. Torrence, Chairman
50 College Street, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL - HILLSBORO—
Orange County Council on Alcoholism
Box 732, Chapel Hill
Mrs. Margaret Rallings, Executive Secretary

CHARLOTTE—
Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellerman, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—
Durham Council on Alcoholism
209 Snow Building—Phone: 2-5227
Mrs. Olga Davis, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr.

GREENSBORO—
Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade— Phone: BRoadway 4-1295
Worth Williams, Executive Director

HENDERSON—
Vance County Program on Alcoholism—Phone: GEneva 8-4714
or GEneva 8-4730
Vance County Health Center,
P. O. Box 233
Rev. Edward Laffman, Director

NEWTON—
Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—
Rockingham County Committee on Alcoholism
119 N. Scales St., P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—
Educational Division, Rowan County ABC Board, P. O. Box 114.
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—
Moore County Alcoholic Education Committee
P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WINSTON-SALEM—
Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone PArk 5-5359

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1200 Blythe Blvd., P. O. Box 4040
CHARLOTTE, N. C.
Phone FR 5-8861
Monday through Friday

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg., 105 W. 4th St.
WINSTON-SALEM, N. C.
Phone: PArk 5-5359
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120

This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

THE ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.